Supreme Court, U.S.
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In The

Supreme Court of the United States

THOMAS TIERNEY and DORIS G. MARAH, individually and on behalf of a class of others similarly situated,

Petitioners,

v.

JOHN HANCOCK FINANCIAL SERVICES, INC., *et al.*,

Respondents.

On Petition For A Writ Of Certiorari To The Supreme Judicial Court Of The Commonwealth Of Massachusetts

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

The Massachusetts legislature enacted a law, Mass. Gen. Laws Ch. 175 § 19E (the "Conversion Law"), authorizing and providing a procedure for domestic mutual life insurance companies to convert to stock companies. The Massachusetts Appeals Court held that this law supercedes the right of the mutual's policyholders to assert claims in a judicial forum for full contractual damages arising by reason of the conversion and limits them only to the consideration approved by the Massachusetts Commissioner of Insurance after a "legislative" hearing held pursuant to the Conversion Law. *Tierney v. John Hancock Financial,* 58 Mass.App.Ct. 571, 791 N.E.2d 925 (2003), *review denied*, 440 Mass. 1104, 797 N.E.2d 380 (2003).

Accordingly, the questions presented are:

1. Does the Contracts Clause, U.S. Const. art. 1, § 10, prohibit the application of the Conversion Law to supercede the right of "participating" policyholders of a mutual life insurance company to enforce their right to contractual damages from the mutual insurer when their mutual insurer converts to a stock life insurance company pursuant to the Conversion Law?

2. Does the Due Process Clause of the Fourteenth Amendment prevent a State from applying the Conversion Law to deny the use of an adjudicatory procedure for actions seeking to enforce contractual damages where the State already has established procedures for adjudication of contractual damage claims?

PARTIES

Petitioners, Thomas Tierney and Doris G. Marah, were participating policyholders of John Hancock Mutual Life Insurance Co.

Respondents are John Hancock Financial Services, Inc., John Hancock Life Insurance Co., and John Hancock Mutual Life Insurance Company; Stephen L. Brown, Chairman of the Board, Chief Executive Officer and Director; Foster L. Aborn, Vice Chairman of the Board, Chief Investment Officer and Director; David F. D'Alessandro, President, Chief Operations Officer and Director; Samuel W. Bodman, III; Joan T. Bok; I. MacAllister Booth; Wayne A. Budd; John M. Connors, Jr.; Robert E. Fast; Edward H. Linde; Dr. Kathleen Foley Feldstein; Nelson S. Gifford; Michael C. Hawley; E. James Morton; Richard F. Syron; Robert J. Tarr, Jr.; and former Directors, Lawrence K. Fish; William L. Boyan; John F. Magee; and Chester V. Vappi; and Honorable Linda Ruthardt, Commissioner of Insurance Commonwealth of Massachusetts.

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OPINIONS BELOW

The Supreme Judicial Court of Massachusetts denied Petitioners' Request For Further Appellate Review as reported at 440 Mass. 1104, 797 N.E.2d 380 (2003). App. 28. The opinion of the Massachusetts Appeals Court (App. 1-27) is reported at *Tierney v. John Hancock Financial,* 58 Mass.App.Ct. 571, 791 N.E.2d 925 (2003). The opinion of the Massachusetts Superior Court is reported at 2000 WL 33223223 (2000). App. 30-51.

JURISDICTION

The denial of Petitioners' Request For Further Appellate Review was entered on October 3, 2003 by the Supreme Judicial Court of the Commonwealth of Massachusetts. App. 28. This Court's jurisdiction is invoked under 28 U.S.C. § 1257(a).

The Petitioners ("Members") filed a Complaint in Massachusetts Superior Court alleging, *inter alia,* that the Commissioner's decision approving a plan to convert John Hancock Mutual Life Insurance Company ("Hancock") from a mutual to a stock life company provided inadequate compensation to policyholders for relinquishment of their contractual interests in Hancock and, if upheld by the court, would constitute a deprivation of property without due process of law. App. 136-181. The Complaint alleged that "Property rights acquired pursuant to the Hancock Charter and Members' contracts cannot constitutionally be taken from Members in the manner proposed by the Plan and the Commissioner does not have authority to approve such an unconstitutional taking. . . . " App. 165. Members also asserted contract damages claims against Hancock.

App. 166-179. In their submissions to the court, Members argued that application of the Conversion Law to preclude full contractual compensation for the relinquishment of their contractual rights would violate the Contracts and Due Process Clause of the United States Constitution. App. 206-214.

On December 19, 2000, the Superior Court entered a memorandum and order dismissing the Complaint pursuant to Mass.R.Civ.P. 12, overruling all of Members' contentions. App. 30-51. The Superior Court expressly noted the Petitioners' Contract and Due Process Clause contentions, but over-ruled them holding that the Commissioner's decision was supported by "substantial evidence." App. 31, 39. The Superior Court construed the Conversion Law to supercede breach of contract and other claims against Hancock, holding them to be improper "indirect challenges" to the Plan. App. 48. The Superior Court held that the Commissioner had decided these claims for contract damages during the administrative proceedings. App. 47-50.

Petitioners appealed to the Massachusetts' Appeals Court. App. 2. They argued that the Superior Court's determination that the Conversion Law superceded their right to adjudicate their contractual damage claims violated the Contracts Clause and the Due Process Clause of the United States Constitution. App. 187-189. Petitioners further argued that they had a state constitutional right to an adjudication of their property rights which could not be abrogated. App. 192-194. The Appeals Court over-ruled these contentions, holding that the contract claims were properly dismissed because they were "indirect challenges" to the Commissioner's decision. App. 23. 58 Mass.App.Ct. at 587-589, 791 N.E.2d at 938-939. The

Appeals Court specifically overruled Petitioners federal constitutional claims, stating that:

> . . . by enacting the conversion statute, the Legislature effectively superseded the provisions of the charter and individual policies. . . . absent a claim that the conversion statute itself violated their rights, the plaintiffs must focus their contract claims on alleged violations of § 19E. See *Municipal Light Co. of Ashburnham v. Commonwealth,* 34 Mass.App.Ct. 162, 171, 608 N.E.2d 743, cert. denied, 510 U.S. 866, 114 S.Ct. 187, 126 L.Ed.2d 146 (1993), quoting from *New Orleans Water-works Co. v. Louisiana Sugar Ref. Co.*, 125 U.S. 18, 30, 8 S.Ct. 741, 31 L.Ed. 607 (1888) (impairment of contract clause in United States Constitution concerns "the legislative power of the State, and not . . . [the] decisions of its courts, or the acts of administrative or executive boards or officers, or the doings of corporations or individuals").

App. 23-24. 58 Mass.App.Ct. at 58, 791 N.E.2d at 938.

Pursuant to Mass.R.App.P. 27.1, Petitioners submitted an application for further appellate review of the decision of the Appeals Court to the Supreme Judicial Court for the Commonwealth Of Massachusetts. App. 28, 197-201. Petitioner argued that the Appeals Court's holding that the Conversion Law "superceded" their right to enforce full compensatory contract damages was contrary to federal constitutional precepts and deprived them of their state constitutional right to a jury trial on their contract claims (citing Mass. Const. Pt. 1, arts. 10, 11 and 15). App. 198-199. The application was denied on October 3, 2003. App. 28.

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

1. The Contracts Clause of Article I of the Constitution, U.S. Const. art. I, § 10, provides: "No state shall . . . pass any Bill of Attainder, *ex post facto* Law, or Law impairing the Obligation of Contracts. . . . "

2. The Due Process Clause of The Fourteenth Amendment, U.S. Const. amend. XIV, provides, *inter alia,* " . . . nor shall any State deprive any person of life, liberty or property, without due process of law. . . . "

3. Mass. Gen. Laws Ch. 175, § 19E, "Conversion From Mutual Company to Stock Company." App. 130-134.

STATEMENT OF THE CASE

In 1862, Hancock began operation as a "mutual life insurance company." App. 140. Hancock issued and delivered insurance contracts on a "mutual basis" for 138 years, premised upon the expectation that it would operate as a mutual life insurance company. App. 140. Members purchased "participating" policies of life insurance from Hancock pursuant to which they made substantial contributions to the surplus of Hancock over the course of many years. App. 140.

In 1991, the Commonwealth of Massachusetts enacted the Conversion Law authorizing domestic mutual life insurance companies to convert to stock life companies. Mass. Gen. Laws Ch. 175 § 19E. App. 130-134. On August 31, 1999, Hancock's Board adopted a Plan of Reorganization (the "Plan") pursuant to the Conversion Law. App. 55. The Plan proposed to convert Hancock from a mutual insurer to a stock life insurer with a parent stock holding

company, John Hancock Financial Services, Inc. ("JHFS"). App. 52, 55.

The Plan proposed to pay cash, policy credits or common stock in JHFS to Members for their contractual interests in Hancock, referred to as "membership interests" by the Conversion Law. App. 53, 82. Under the Plan, the total value of all "membership interests" or aggregate consideration was proposed to be determined by the price set by Hancock management and its underwriters for the initial public offering of stock in JHFS which was to occur after the Commissioner approved the Plan. App. 82. The Plan provided that Members would take this consideration in the form of cash, unless specific Members requested otherwise (the "Cash-Out Provision"). App. 82. The anticipated or appraised fair value of this aggregate consideration was never disclosed to Members before implementation of the Plan. App. 158-160.

The Plan then proposed to allocate this aggregate consideration to each eligible policyholder based upon the amount of their past and anticipated future contributions to statutory surplus. Under this formula, each Member received a "fixed" amount (17 shares) of common stock for each eligible policy owned. App. 65-69. Each Member was also entitled to receive a "variable" amount of shares (App. 68-69), based upon actuarial formulas which sought to measure each Members' (1) past contributions to statutory surplus using historical experience; and (2) expected future contributions to statutory surplus using projected future experience. (The "Historic Plus Formula").

The Plan also proposed a "Closed Block" in order to provide benefits and purported reasonable dividend expectations. App. 92. The Plan's "Closed Block" segregated a specific set of invested assets for the benefit of

individual policyholders with "participating" policies. App. 92-97.

The Plan was submitted to the Massachusetts Commissioner of Insurance (the "Commissioner") for approval pursuant to the Conversion Law. App. 55. The Conversion Law requires that the Commissioner determine that any such plan "conform[s] to the requirements of the statute" and "is not prejudicial to the policyholders" of the converting company. Mass. Gen. Laws Ch. 175 § 19E(1). Appendix G. In making this determination, the Commissioner must also determine whether the Plan provides "appropriate consideration" in exchange for all of the "membership interests." Appendix G, § 19E(3).

In the administrative proceedings, the Commissioner ruled that she had no jurisdiction to adjudicate any contract or related claims of policyholders arising from the proposed transaction. App. 126. (" . . . the Division is not adjudicating . . . those interests . . . but rather Hancock's statutory right to demutualize."). On November 17 and 18, 1999, the hearing officer held a public hearing. App. 59. A policyholder vote was held, in which less than 25% of Hancock's approximately three million members participated, with a majority of those voting in favor. App. 64-65.

On December 9, 1999, the Commissioner approved the Plan by a written decision. Appendix E. The Plan was implemented on January 27, 2000, when John Hancock Financial Services, Inc. ("JHFS") conducted an Initial Public Offering ("IPO").

On January 7, 2000, Members filed a class action complaint in Massachusetts Superior Court which was replaced by a First Amended Complaint. ("Complaint").

Appendix H. The Complaint combined both an administrative review claim against the Commissioner pursuant to Mass. Gen. Laws Ch. 30A, § 1 *et seq.* (App. 164-165) with additional civil claims, including various breach of contract claims, against Hancock for contract damages arising by reason of the implementation of the Plan. App. 165-171.

The claims against Hancock allege that the Plan, when implemented, failed to provide Petitioners full compensatory contractual damages for their interest in Hancock at the point of demutualization. App. 139. The Complaint alleges that the Plan "discounted" Members' contractual interests in Hancock in three material respects. *First*, the Complaint alleges that the total or aggregate value of Members' interest in Hancock was substantially discounted because it was based upon the IPO price which did not reflect the full or fair value of Hancock and, therefore, Members' interests. App. 153-156. As a result, the Complaint alleges that the Plan severely shortchanged Members by not paying them the full value of their interest in Hancock which they alone created through their premium contributions. App. 155-160.

Second, the Complaint alleges that the Plan's "historic-plus" allocation formula resulted in discounted compensation to long term individual policyholders because it was based upon projected future contributions to statutory surplus, rather than "historic-only" contributions. App. 146. *Third*, the Complaint alleges that Members' rights to a "participating" contract of insurance was not fully compensated by the Plan's "Closed Block" which operates them on a "*non*participating basis" thus depriving Members of their contractual right to share in divisible surplus for the purpose of obtaining "insurance at cost." App. 147-150.

On December 19, 2000, the Superior Court entered a memorandum and order dismissing the Complaint pursuant to Mass.R.Civ.P. 12. Appendix D. With respect to the claim for judicial review against the Commissioner, the Superior Court held that the Commissioner's decision was supported by "substantial evidence." App. 46. The Superior Court then held that the claims seeking contractual damages against Hancock were improper "indirect challenges" to the Plan. App. 48. The Superior Court held that the Commissioner had decided these claims for contract damages during the administrative proceedings notwithstanding the Commissioner's express ruling that she was *not* adjudicating any of Members' claims for contract damages. App. 48.

On July 17, 2003, the Appeals Court affirmed the judgment of the Superior Court. *Tierney v. John Hancock Mutual Life,* 58 Mass.App.Ct. 571, 791 N.E.2d 925 (2003). Appendix A. The Appeals Court recognized that Members held contractual interests in Hancock, including a right to the entire surplus, a right to vote and a right to share in the assets upon liquidation. App. 6. 58 Mass.App.Ct. at 576, 791 N.E.2d at 930. However, the Appeals Court ruled that the contract, common law and statutory claims in Counts II-IX were properly dismissed because they were "indirect challenges" to the Commissioner's decision. App. 23. 58 Mass.App.Ct. at 588, 791 N.E.2d at 939. The court stated that by enacting the conversion statute, the Legislature "superseded" the provisions of Members' contracts (*i.e.*, the charter and individual policies). App. 23. 58 Mass.App.Ct. at 588, 791 N.E.2d at 938. The court concluded that any claims that these contractual rights were not adequately compensated by the conversion had to arise under the Conversion Law, not through judicial causes of

action pursuant to Members' contracts or Hancock's fiduciary duties. App. 23. *Id.*

The Appeals Court, however, held that Members could not assert any claims under the Conversion Law because the Commissioner's decision was supported by "substantial evidence." App. 4. Nonetheless, the Appeals Court noted that the Commissioner "made no explicit findings on the fairness of using an IPO to determine the aggregate value of their interests." App. 10-11. 58 Mass.App.Ct. at 578, 791 N.E.2d at 932. The Appeals Court explained:

> [The Commissioner] made no explicit findings on the fairness of using an IPO to determine the aggregate value of policyholders' interests. Nor does it appear that she solicited expert advice on the question in this proceeding. . . . [The Commissioner's consultant,] Wasserstein Perella's opinion letter . . . stated "You have not asked for our opinion and we do not express any opinion as to . . . (4) the terms of an IPO, if any, the IPO Price . . . or the fair market value of any shares of Holding Company Common Stock to be issued pursuant to the Plan or the price at which the Holding Company Common Stock issued in connection with the Plan or pursuant to the IPO will trade."
>
> Notwithstanding the absence of any opinion on the fairness of the IPO terms, *Wasserstein Perella had provided the commissioner with documentation illustrating what it called an "IPO discount," which appears to be yet another term for the alleged undervaluing of their interests* complained of by the plaintiffs and which the commissioner had acknowledged in her earlier decision on the demutualization of the State Mutual Life Assurance Company. (Emphasis added).

App. 10-11. *Id.* Under the deferential standard applicable to administrative "legislative" hearings in Massachusetts, the Appeals Court held that the Commissioner's decision was supported by "substantial evidence."[1] App. 12-14. Judgment was therefore entered against Members on their contract damage claims against Hancock " . . . because they are not entitled to the relief they seek." 58 Mass.App.Ct. 590, 791 N.E.2d at 940. App. 27.

Pursuant to Mass.R.App.P. 27.1, Petitioners submitted an application for further appellate review of the decision of the Appeals Court to the Supreme Judicial

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[1] The Conversion Law did *not* provide for an adjudicatory proceeding in which Members were named parties. Appendix G. In other contexts, Massachusetts may provide for a right of "adjudication" before administrative agencies. Mass. Gen. Laws Ch. 30A, § 1. An "adjudicatory" proceeding is defined as a proceeding before an agency in which the legal rights, duties and obligations of specifically named persons are required by constitutional right to be determined. Mass. Gen. Laws Ch. 30A, § 1(1). This right only applies to persons named as "parties" to the administrative proceeding. Mass. Gen. Laws Ch. 30A, § 1(3). A "party" is a specifically named person to the proceeding whose legal rights and obligations are being determined. Mass. Gen. Laws Ch. 30A, § 1(3). Parties have full trial type rights before the agency to call witnesses, introduce evidence, cross-examine witnesses, rebut evidence and conduct discovery. Mass. Gen. Laws Ch. 30A, §§ 11 and 12. Any person aggrieved by an administrative determination in an adjudicative proceeding may seek judicial review in court. Mass. Gen. Laws Ch. 30A, § 14. Any factual decisions made by the agency are said to be "final" and may not be disturbed unless clearly erroneous and unwarranted. Review by "*trial de novo*" is provided only if allowed by a particular statute. Mass. Gen. Laws. Ch. 30A, § 14. Members were not named as parties and the Conversion Law makes no right to *de novo* judicial review or to "adjudicate" the contract compensation issue in a judicial proceeding. Mass. Gen. Laws Ch. 175, § 19E.

Court for the Commonwealth of Massachusetts which was denied. Appendix B.

REASONS FOR GRANTING THE PETITION

Certiorari should be granted because the opinion of the Massachusetts Appeals Court violates the Contracts and Due Process Clauses as construed by this Court. The questions presented are of substantial public importance because they affect the rights of millions of mutual policyholders.[2] The court below eliminated the right of these mutual policyholders to enforce their right to full compensatory contract damages caused by the implementation of a plan of demutualization.

Members do *not* seek to reverse or prohibit the conversion; they seek only the right to adjudicate the full compensatory value of their contractual interests in Hancock which were extinguished by the demutualization. This right to enforce contractual damages is of paramount concern to mutual policyholders because such actions ensure that mutual conversions are not used to distribute membership values to benefit other interests such as company insiders and Wall Street.[3] Certiorari should be accepted to address the rights of mutual policyholders to

[2] Most mutual life insurers have demutualized or will demutualize pursuant to recently enacted conversion laws. *See* Smallenberger, *Restructuring Mutual Life Insurance Companies: A Practical Guide Through the Process*, 49 Drake L. Rev. 513, 517 (2001). *See* Racz, *No Longer Your Piece of the Rock: The Silent Reorganization of Mutual Life Insurance Companies*, 73 N.Y.U. L. Rev. 999, 1002-1003 (June 1998).

[3] *Cf. SEC v. Jakubowski*, 150 F.3d 675 (7th Cir. 1998).

enforce their contractual right to damages in connection with a mutual to stock company conversion.

I. The Holding Of The Massachusetts Appeals Court That The Conversion Law Supercedes The Right To Enforce Contract Damages Under A Mutual Life Insurance Contract Conflicts With The Contracts Clause As Construed By This Court In *Richmond Mortgage*

The Appeals Courts applied the Conversion Law to relieve Hancock from its duty to pay full compensatory contract damages resulting from a plan of conversion and, therefore, violated the Contracts Clause. 58 Mass.App.Ct. 571, 588, 791 N.E.2d 925, 938. The court found that any pre-existing right to enforce contract damages had been replaced by the administrative procedure under the Conversion Law. 58 Mass.App.Ct. at 589, 791 N.E.2d at 937. The Members, however, were not permitted to adjudicate or enforce their right to contractual damages in the administrative proceedings. App. 26. Nor were Members permitted to adjudicate their contract damage claims in a judicial forum since, upon attempting to do so, the court held that the contract claims had already been determined by the Commissioner, even though she had expressly disclaimed any such adjudication of the contract claims. App. 23-26. This "Catch-22" violated the Contracts Clause.

A state legislature may modify, limit, or alter the remedy for enforcement of a contract without impairing its obligation, but in so doing, it may not deny all remedy or so circumscribe the existing remedy with such conditions and restrictions as seriously impair the value of the right. *Richmond Mortgage & Loan v. Wachovia Bank,* 300 U.S. 124, 128 (1937) and *Edwards v. Kearzey,* 96 U.S. 595, 600

(1877). As this Court explained in *Edwards v. Kearzey,* 96 U.S. at 600, the Contracts Clause encompasses the right to enforce a contract:

> The obligation of a contract includes everything within its obligatory scope. Among these elements nothing is more important than the means of enforcement. This is the breath of its vital existence. Without it, the contract, as such, in the view of the law, ceases to be, and falls into the class of those 'imperfect obligations,' as they are termed, which depend for their fulfillment upon the will and conscience of those upon whom they rest.

Laws which relate to the enforceability of contracts are subject to Contracts Clause analysis because, otherwise, contracts would be " . . . reduced to simple, unenforceable promises." *General Motors v. Romein,* 503 U.S. 181, 189 (1992). *See also Sturges v. Crowninshield,* 17 U.S. 122, 197-198 (1819) and *McCracken v. Hayward,* 43 U.S. 608, 612 (1844) ("The obligation of a contract consists in its binding force on the party who makes it. . . . If any subsequent law affects to diminish the duty, or to impair the right, it necessarily bears on the obligation of the contract.") For this reason, changes in the laws that make a contract legally enforceable may trigger Contract Clause scrutiny if they impair the obligation of pre-existing contracts, even if they do not alter any of the contract's bargained-for terms. *Bronson v. Kinzie,* 42 U.S. 311, 316, 11 L.Ed. 143 (1843) (law limiting foreclosure rights); *McCracken, supra,* 43 U.S. at 611-614 (same).

A law allowing a party to avoid performance of a contract does not suffice for an impairment; the law must also cut-off the remedy for the non-performance. *Hays v. Port of Seattle*, 251 U.S. 233, 237 (1920). The obligation

created by a contract involves both the obligation to perform or to pay damages for nonperformance. *Horwitz-Matthews, Inc. v. City of Chicago,* 78 F.3d 1248, 1251 (7th Cir. 1996). If the second alternative remains, the contract is not impaired. *Id.* An impairment arises only if the duty to pay damages for nonperformance is eliminated by the state. This principle was further explained in *E&E Hauling v. Forest Preserve District,* 613 F.2d 675, 679 (7th Cir. 1980):

> . . . if a state or its subdivision passes a law and through enforcement of it prevents another party from fulfilling its obligation under the contract because the use of the ordinance precludes a damage remedy, the non-breaching party cannot be made whole. Instead, the law has impaired the obligation of the contract. Use of law normally will preclude a recovery of damages because the law will be a defense to a suit seeking damages unless it is clear the law is not to have that effect.

The Appeals Court eliminated Hancock's duty to pay full, compensatory contractual damages as determined by a court and, therefore, operated as an impairment. Under their contracts, Members had not only insurance protection, but also an equity-like interest in the company. Department Of Treasury, *Report To The Congress On Property And Casualty Insurance Company Taxation* (Apr. 1991) ("A participating policy is one through which a policyholder effectively buys not only insurance protection, but also an equity-like interest in the insurance company"); Department Of Treasury, *Final Report To The Congress On Life Insurance Company Taxation* at 23 (Aug. 1989). A mutual to stock conversion requires the extinguishment of the "equity-like interest" in order to effectuate new

corporate ownership by stock holders. Members were precluded from enforcing in a contract action their assertion that the payment for this "equity interest" was insufficient. Their contracts were, therefore, impaired.[4]

The Appeals Court completely eliminated the right of mutual policyholders to enforce their contracts, substituting instead a unilateral procedure under the Conversion Law whereby Hancock proposed and the Commissioner approved the amount of contract damages to be provided to Members for the relinquishment of their contractual interests in Hancock. This violated the Contracts Clause.

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[4] The decision of the Appeals Court conflicts with decisions of the Second, Fifth and Seventh Circuits which hold that 42 U.S.C. § 1983 does not apply to provide a remedy for policyholders because a state conversion statute provides the "mere approval" of a corporate business transaction and does not cut-off state judicial remedies. Accordingly, the approval under a conversion law does not give rise to "state action." *Cf. Gayman v. Principal Financial Servs., Inc.*, 311 F.3d 851 (7th Cir. 2002), *cert. denied*, 123 S.Ct. 2610 (2003); *Campbell v. John Hancock*, 61 Fed. Appx. 918, *cert. denied*, 124 S.Ct. 75 (2003); *Tancredi v. Metropolitan Life Ins. Co.*, 316 F.3d 308 (2nd Cir. 2003), *cert. denied*, 123 S.Ct. 2610 (2003). The Seventh Circuit explained that if, in a mutual conversion, the policyholder's consideration is inadequate, the proper remedy is a suit in state court under state law, not a claim under § 1983. *Gayman v. Principal Life*, 311 F.3d at 853 *citing SEC v. Jakubowski*, 150 F.3d 675 (7th Cir. 1998). The Appeals Court holds that no state remedy exists.

II. The Denial Of Established Procedures To Adjudicate The Right To Contractual Damages Conflicts With The Requirements Of The Due Process Clause As Set Forth By This Court In *Logan v. Zimmerman Brush*

The Due Process Clause prevents the States from denying litigants use of established adjudicatory procedures, when such an action would be the "equivalent of denying them an opportunity to be heard upon their claimed rights." *Logan v. Zimmerman Brush,* 455 U.S. 422, 429-30 (1982) *citing Boddie v. Connecticut,* 401 U.S. 371, 380 (1971). A state violates the Due Process Clause when it provides a cause of action for the redress of a claim in an adjudicatory procedure, but then itself prohibits a claimant from utilizing those procedures. 455 U.S. at 433.

Here, the Appeals Court held that the Conversion Law provided the procedure by which Members' claims for contractual damages against Hancock were to be adjudicated, but Members were never permitted to appear to adjudicate those claims in the proceedings. Nor were they permitted to exercise their right to jury trial under the state constitution. Mass. Const. Pt. 1, arts. 10, 11 and 15; *Lavelle v. Massachusetts Comm. Against Discrimination,* 426 Mass. 332, 688 N.E.2d 1331 (1997). The elimination of Members' right to the use of any of these established procedures to adjudicate their claim to compensatory contract damages violates basic principles of due process.

At a minimum, the Due Process Clause requires that a "deprivation of life, liberty or property by adjudication be preceded by notice and opportunity for hearing appropriate to the nature of the case." *Logan,* 455 U.S. at 428. The inquiry is twofold: whether a protected interest has been

deprived and, if so, what process was due. *Id.* A cause of action is a species of property protected by the Fourteenth Amendment. *Id. citing Mullane v. Central Hanover Bank,* 339 U.S. 306, 311 (1950). At least some form of a hearing is required before the owner is finally deprived of that interest. *Id.* In any event, every civil litigant is entitled to a hearing on the merits unless the litigant fails to comply with a reasonable procedural or evidentiary rule. *Id.* at 438.

Members' right to enforce their contractual interests in Hancock to obtain contract damages constitutes a property interest. The legislative proceeding under the Conversion Law did not suffice to eliminate this interest since it did not provide Members with the right to adjudicate the value of their contractual damages. Where the value of contractual damages is at stake, Members are entitled to all the attributes of a judicial hearing with a right to present evidence, confront and cross-examine witness, present argument, and have legal counsel. *Goldberg v. Kelly,* 397 U.S. 254 (1970).[5] Due Process requires these protections because they ensure the accuracy of any governmental factual findings. *Id.* at 270. Here, the Commissioner made a unilateral factual finding that the consideration paid to Members for the extinguishment of their interests in Hancock was appropriate. The Appeals

[5] Even if the Commissioner was designated to initially make a unilateral determination of the value of consideration to be provided, due process entitled Petitioners to a *de novo* judicial review with a right to trial on the valuation issue. *Cf. Bragg v. Weaver*, 251 U.S. 57, 58-59 (1919); *Bailey v. Anderson*, 326 U.S. 203, 205 (1945) ("Its value may be fixed by viewers without a hearing . . . if their award is subject to a review in which a trial on the evidence may be had.").

Court noted that this finding did not provide the full compensatory value of Members' contractual interest, but then nevertheless deferred to the Commissioner's finding. The denial of an adjudicatory hearing prevented Members from establishing that the value paid to them was erroneously discounted and did not provide full compensatory contractual damages. The failure to provide Members a right to adjudicate their contract damages arising under their contractual interests in Hancock violates Due Process.

CONCLUSION

Wherefore, it is respectfully requested that this Honorable Court grant Certiorari.

Respectfully submitted,

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Dated: December 26, 2003

APPENDIX A

791 N.E.2d 925

Appeals Court of Massachusetts,
Suffolk.

Thomas TIERNEY & another[1]
v.
JOHN HANCOCK MUTUAL LIFE
INSURANCE COMPANY & others.[2]

No. 01-P-435.

Argued Oct. 16, 2002.
Decided July 17, 2003.

Douglas H. Wilkins, Cambridge, for the plaintiffs.

Peter T. Wechsler, Assistant Attorney General, for Commissioner of Insurance.

Edwin G. Schallert, of New York, for John Hancock Mutual Life Insurance Company & others.

Present: CYPHER, SMITH, & GRASSO, JJ.

CYPHER, J.

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[1] Doris G. Marah. The complaint also recites that it is a class action, and that the two named plaintiffs brought their claims "individually and on behalf of other similarly situated policyholders." However, there is no indication in the record of the meaning of this phrase, or that class action status was sought under Mass.R.Civ.P. 23, 365 Mass. 767 (1974).

[2] The Commissioner of Insurance, John Hancock Financial Services, Inc., and John Hancock Life Insurance Company. The complaint also names individual directors and former directors of John Hancock Mutual Life Insurance Company. (We refer to the three Hancock companies and the directors and former directors collectively as the "Hancock defendants.")

In this G.L. c. 30A appeal,[3] the plaintiffs, Thomas Tierney and Doris Marah, challenge a Superior Court judge's decision on cross motions for judgment on the pleadings. The judge upheld the decision of the Commissioner of Insurance (commissioner) approving the plan of John Hancock Mutual Life Insurance Company (JHM) to convert from a privately held mutual insurance company to a publicly traded stock company (plan), John Hancock Financial Services (JHFS). The judge also dismissed the plaintiffs' related claims against the Hancock defendants for breach of contract, breach of fiduciary duty, and violation of G.L. c. 93A, the Consumer Protection Act.

The plaintiffs argue that the commissioner's approval of the plan violated G.L. c. 175, § 19E, the statute governing such conversions, for the following reasons: (1) the aggregate compensation provided to policyholders (also called "members") under the plan was inadequate; (2) the formula used in the plan to allocate consideration among policyholders was unfair and effected an unconstitutional taking of their property; and (3) the segregation of members' policies into a "closed block" deprived them of possible increases in future dividends. Last, the plaintiffs appeal from the Superior Court's conversion of the Hancock defendants' motion to dismiss counts II through X into a motion for summary judgment and the dismissal of those counts. We affirm.

1. *Background.* In 1998, JHM sought to convert from a mutual company to a stock company, pursuant to G.L.

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[3] The plaintiffs also sought declaratory relief pursuant to G.L. c. 231A.

c. 175, § 19E, through a process known as demutualization. Accordingly, JHM submitted a reorganization plan to the commissioner. In November, 1998, the commissioner formed a working group of Division of Insurance staff members and outside consultants, including an actuarial firm, an accounting firm, an investment banking firm, and a law firm, to provide independent advice and assistance in evaluating the plan, pursuant to § 19E. The working group reviewed proposed drafts of the plan and made numerous recommendations to JHM for improvement to the plan.

On August 31, 1999, JHM's board of directors adopted the plan and sought approval from the commissioner. The plan proposed made JHM a subsidiary of a holding company and provided eligible policyholders with stock, cash, or policy credits in exchange for their interests in the mutual company. In September, 1999, JHM sent eligible policyholders a demutualization package consisting of a policyholder information statement, an information guide, a policyholder record, a ballot, taxpayer identification, and a cash/stock compensation card.

On November 17 and 18, 1999, a public hearing on the plan was held. Both plaintiffs submitted written materials. Tierney spoke, as did counsel for Marah.

On November 30, 1999, a special meeting of policyholders was held to vote on the plan, as required by § 19E. JHM reported to the commissioner that 93.72 percent of the votes cast by policyholders were in favor of the plan.

On December 9, 1999, the commissioner issued a decision approving the plan, deeming it in compliance with G.L. c. 175, § 19E. The commissioner found that the plan

provided eligible policyholders with appropriate consideration in exchange for their membership interests in JHM and that the allocation of consideration under the plan was based upon a fair and reasonable formula.

The plaintiffs brought this complaint on January 7, 2000, seeking judicial review under G.L. c. 30A, § 14(7). JHM implemented the plan on January 27, 2000. Subsequently, the plaintiffs amended their complaint to include damages caused by the plan's implementation.

After a hearing, the trial judge allowed the commissioner's motion for judgment on the pleadings, denied the plaintiffs' cross motion, and allowed the Hancock defendants' motion to dismiss all other counts. The judge concluded that the commissioner's decision was supported by substantial evidence, was not based on an error of law, and was not arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.

2. *Aggregate value of JHM – appropriate consideration.* The commissioner concluded that the plan provided all policyholders with appropriate consideration. We agree. There was substantial evidence that there was appropriate consideration based on a fair and reasonable formula. Such evidence included an anti-takeover provision in the demutualization plan as allowed by § 19E; written and oral testimony that the policyholders received JHM's entire surplus; and reports by both JHM's outside financial advisor and the commission's own independent financial advisor that the policyholders received appropriate, fair, and reasonable consideration. The plaintiffs have failed to present any evidence, beyond mere conclusions, that the plan did not provide them with appropriate consideration. See *Pinecrest Village, Inc. v. MacMillan,* 425

Mass. 70, 75, 679 N.E.2d 216 (1997) (absent powerful evidence to the contrary, expert technical knowledge of an administrative agency should not be disturbed).

The plaintiffs offer two reasons to support their claim that the commissioner erred in concluding that the plan provided appropriate consideration. First, the plaintiffs contend that the plan's definition of "member interests" was too narrowly construed under § 19E(3). Second, the plaintiffs argue that, by determining policyholders' compensation by means of an initial public offering (IPO), the plan undervalued JHM.

a. *Member interests.* The plan compensated members for the loss of their right to elect the directors, and for their portion of the company's surplus. Members were also assured continued dividends into the future, after demutualization. The plan is consistent with G.L. c. 175, § 19E(3), as amended by St.1993, c. 226, § 14A, which provides in pertinent part:

> "In exchange for all membership interests in the company, such plan shall give each eligible policyholder appropriate consideration . . . [which] shall be based upon the insurer's entire surplus. . . ."

The plan defined membership interests as "all the rights or interests in respect of each insurance policy and annuity contract of [JHM] including, but not limited to, any right to vote and any rights which may exist with regard to the surplus of [JHM] not apportioned or declared prior to the Effective Date by the Board for policyholder dividends, including any such rights in liquidation or reorganization of [JHM], but shall not include any other benefits, values, guarantees, dividend rights or other

rights expressly conferred by an insurance policy or annuity contract."[4]

The plan's definition of member interests is consistent with independent industry materials submitted by the parties with the record appendix, which consistently describe membership interests as principally including voting rights, a right to surplus, and a right to a share in the assets upon liquidation of the company. See Actuarial Standards Board, Allocation of Policyholder Consideration in Mutual Life Insurance Company Demutualizations, Exposure Draft 2 (April 1999) (Exposure Draft) ("[t]ypical membership rights include liquidation rights and voting rights"); Dye, Distributing Consideration to Policyholders, 648 Practicing L. Inst. 75, 81 (1993) (Dye) ("[s]uch [membership] rights include [i] the right to vote on matters submitted to a vote of policyholders and [ii] the right to share in the distribution of assets of the mutual, after provision for all liabilities, upon liquidation"); Society of Actuaries, Report of the Task Force on Mutual Life Insurance Company Conversion, 39 Transactions 295, 300 n.3 (1988) (SOA Task Force Report) ("[m]embership rights include, principally, the right to receive dividends [surplus], to elect directors and to receive the net value of the company in the event of its liquidation"). See also *Keystone Auto. Club Cas. Co. v. Commissioner of Int. Rev.*, 122 F.2d 886, 890 (3d Cir.1941), *cert. denied*, 315 U.S. 814, 62 S.Ct.

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[4] The policyholders' membership interests do not include the policyholders' contractual rights arising under their insurance policies or annuities because the demutualization does not reduce the policy benefits, values, premiums, guarantees or policy dividend rights. See Dye, Distributing Consideration to Policyholders, 648 Practicing L. Inst. 75, 83 (1993).

799, 86 L.Ed. 1213 (1942); *Mutual Fire Ins. Co. v. United States*, 142 F.2d 344, 346, 348 (3d Cir.), *cert. denied*, 323 U.S. 729, 65 S.Ct. 65, 89 L.Ed. 585 (1944); *Mutual Benefit Life Ins. Co. v. Herold*, 198 F. 199, 206-212 (D.N.J.1912), *aff'd*, 201 F. 918 (3d Cir.), *cert. denied*, 231 U.S. 755, 34 S.Ct. 323, 58 L.Ed. 468 (1913).

The plaintiffs argue that the plan did not compensate them for *all* of their membership interests as required by § 19E(3). Specifically, the plaintiffs contend that the plan failed to provide consideration for their "ownership interests," alternatively characterized as beneficial, equitable, or legal interests.

There was no error. "[P]olicyholders, unlike stockholders in a corporation, do not have an ownership interest that can be transferred to others[;] they nevertheless have a financial interest in the mutual insurance company. Policyholders are entitled to participate in the annual surplus of the company, which represents excess premiums or overcharges paid by the policyholders." *Harhen v. Brown,* 46 Mass.App.Ct. 793, 808 n. 14, 710 N.E.2d 224 (1999), *S.C.,* 431 Mass. 838, 730 N.E.2d 859 (2000) (rev'd on other grounds). The plaintiffs' argument that a demutualization is equivalent to a liquidation, and thus, the aggregate distribution should have been larger, is also unavailing. See *UNUM Corp. v. United States,* 130 F.3d 501, 516 (1st Cir.1997), cert. denied, 525 U.S. 810, 119 S.Ct. 42, 142 L.Ed.2d 32 (1998) ("[t]he very nature of a demutualization fundamentally distinguishes it from a liquidation in that the insurer is still in business after the conversion is complete").

Here, the plan provided policyholders consideration for their membership interests, as required by the statute.

We conclude that the policyholders were not entitled to a distribution of assets, because there was no liquidation.

b. *Initial public offering.* The commissioner approved a process that relied on an IPO containing anti-takeover provisions to determine the aggregate value of members' interests.[5] For policyholders receiving their compensation through cash or policy credits, the plan contained a "top-up" provision, by which the value assigned to their interests was limited to the average IPO stock price paid within the first twenty days of trading, up to a maximum of 120 percent of the IPO price. The plaintiffs contend that these limitations unfairly depressed the value of their interests: the anti-takeover provisions, which prohibited acquisition of a controlling interest in JHFS, thereby removed from the marketplace the value represented by the amount investors would be willing to pay if they could gain control of the company.[6] To remedy this, the plaintiffs advocate the addition of a premium[7] to the value established by the IPO

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[5] The plan contained an absolute anti-takeover restriction for two years, with an additional one-year restriction on any hostile takeover. During this period, acquisitions of JHFS stock by any one person, or persons acting in concert, were limited to less than ten percent of the outstanding shares of common stock. General Laws c. 175, § 19E(9), specifically authorizes the use of an anti-takeover provision in a demutualization plan.

[6] This is referred to as a "minority discount." "A minority discount recognizes that controlling shares [of stock] are worth more in the market than are noncontrolling shares." *Shear v. Gabovitch,* 43 Mass.App.Ct. 650, 678, 685 N.E.2d 1168 (1997), quoting from 12B Fletcher, Cyclopedia of Private Corporations § 5906.120, at 435 (1993).

[7] Called a "control premium" – "[a]n amount (expressed in either dollar or percentage form) by which the pro rata value of a controlling interest exceeds the pro rata value of a noncontrolling interest in a

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in order to achieve a fair aggregate value for their interests. Further, the plaintiffs argue that the market experience in the first twenty days of trading would not be representative of the stock's true market value, which could not be determined until after the anti-takeover provisions expired. This created what the plaintiffs have called a "market discount" of their interests, which, they assert, could be remedied by establishing the company's value by means of an appraisal.[8]

Analogizing themselves to dissenting stockholders of a company being acquired, the plaintiffs refer to case law in which the "fair value," see G.L. c. 156B, § 92, as amended by St.1983, c. 522, § 22, of the dissenting stockholders' shares is determined by statutory appraisal rights. The plaintiffs cite the "Delaware block" method, which factors market value, earnings value, and net asset value, and assigns a percentage to each of these in a manner that fits the particular company, as an appropriate model for determining the "fair value" of a company. See *Piemonte v. New Boston Garden Corp.*, 377 Mass. 719, 724, 387 N.E.2d 1145 (1979); *Sarrouf v. New England Patriots Football Club, Inc.*, 397 Mass. 542, 548 & nn.8, 9, 492 N.E.2d 1122 (1986); *BNE Mass. Corp. v. Sims*, 32 Mass.App.Ct. 190,

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business enterprise." Pratt, Business Valuation Discounts and Premiums 18 (2001).

[8] The plaintiffs cite no authority, and we find none, that discusses "market discount." A similar term, "marketability discount," applies to closely-held corporations. See *Lawson Mardon Wheaton, Inc. v. Smith*, 160 N.J. 383, 398-399, 734 A.2d 738 (1999) ("marketability discount," as opposed to "minority discount," "adjusts for a lack of liquidity in one's interest in an entity, on the theory that there is a limited supply of potential buyers for stock in a closely-held corporation").

194-195 & n. 8, 588 N.E.2d 14 (1992). Under this approach, actual market value (i.e., the historic price of stock shares) is a relevant factor in determining "fair value" only if there is an established market for a particular stock. *Piemonte v. New Boston Garden Corp.*, 377 Mass. at 725, 387 N.E.2d 1145. Since there was no established market for JHFS, the plaintiffs argue that use of the IPO to establish the value of members' interests was inappropriate.

We note first that, by the terms of G.L. c. 175, § 30(2), the appraisal rights provided for in G.L. c. 156B, §§ 86-98, are inapplicable to insurance companies. Second, while the Legislature could have required an appraisal to determine the aggregate value to be distributed to policyholders, see, e.g., the California and Wisconsin demutualization statutes, discussed in Dye, *supra* at 101-103, it did not do so. Rather, our demutualization statute requires that eligible policyholders be given "appropriate consideration" for their interests, determined under "a fair and reasonable formula approved by the commissioner." G.L. c. 175, § 19E(3).

Although the commissioner found that the plan provided all policyholders with appropriate consideration, she made no explicit findings on the fairness of using an IPO to determine the aggregate value of policyholders' interests. Nor does it appear that she solicited expert advice on the question in this proceeding. For example, the firm of Wasserstein Perella & Co. was retained by the commissioner to provide "an opinion as to the fairness, from a financial point of view, to the Eligible Policyholders of the John Hancock Mutual Life Insurance Company . . . as a group, of the exchange of the aggregate Policyholders' Membership Interests for shares of Holding Company

Common Stock, cash and Policy Credits, pursuant to the Plan of Reorganization . . . . " While opining that the plan was fair to eligible policyholders, Wasserstein Perella's opinion letter, prepared for the commissioner and dated September 1, 1999, also stated, "You have not asked for our opinion and we do not express any opinion as to . . . (4) the terms of an IPO, if any, the IPO Price and, in the absence of an IPO, such other price used to determine distributions to Eligible Policyholders pursuant to the Plan, or the fair market value of any shares of Holding Company Common Stock to be issued pursuant to the Plan or the price at which the Holding Company Common Stock issued in connection with the Plan or pursuant to the IPO will trade."

Notwithstanding the absence of any opinion on the fairness of the IPO terms, Wasserstein Perella had provided the commissioner with documentation illustrating what it called an "IPO discount," which appears to be yet another term for the alleged undervaluing of their interests complained of by the plaintiffs, and which the commissioner had acknowledged in her earlier decision on the demutualization of the State Mutual Life Assurance Company. See the commissioner's findings, conclusions, and order in Plan of Reorganization of State Mutual Life Assurance Company of America, Docket No. F-95-1, at 29 (Aug. 2, 1995) (*State Mutual*)[9]: "[T]here is often a discount

[9] State Mutual was the first insurer to file a plan to demutualize under § 19E; Hancock is the second. In 1995, the commissioner approved State Mutual's demutualization plan. That plan was not appealed, under the conditions of a settlement agreement entered into by State Mutual, the Center for Insurance Research, and certain policyholders.

to the market value of a company in the pricing of an IPO. . . . " The reasons for such a discount were listed in the Wasserstein Perella documents,[10] as was the history of periodic increases in the stock prices of demutualized life insurance companies for one year after their initial public offerings.[11] The question of market increases after the date of the IPO offering was addressed in the commissioner's decision in the instant matter:

> "[T]he Plan's 'top-up' provision is beneficial to eligible policyholders because it allows those who receive cash or policy credits to share in the benefit of any short-term appreciation in the stock price without being subjected to the down-side risk of stock ownership. We note that, according to Hancock, it is the only insurer to date to offer such a benefit in its demutualization plan."

Thus, the plaintiffs' essential argument that they should receive some sort of premium above the IPO value was addressed by the commissioner, who found that the twenty-day/120 percent "top-up" provision served that purpose. Whether the period should have been longer, or

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[10] Wasserstein Perella's explanation for the IPO discount included: "Compensate investors for investing in entity with no public company track record

– IPO stocks have no trading/valuation history to rely on;

– Less public information available regarding the Company's management, products, and strategy."

[11] Wasserstein Perella submitted to the commissioner a chart tracking price changes in ten demutualized companies which showed that the average change in stock price was +15.3 percent twenty days after the IPO; +18.6 percent after sixty days; +14.8 percent after ninety days; and +56.0 percent after one year.

the percent higher, see note 11, *supra,* was a matter left to the commissioner's wide discretion under § 19E(3).

As noted above, the commissioner made no explicit findings on the broader question of the fairness of using an IPO (as against, e.g., an appraisal) as the means to establish the value of policyholders' interests. However, in her decision in the *State Mutual* proceeding (which is part of the administrative record before us), the commissioner made extensive findings on the question:

> "As a means of determining the price per share of the common stock, I find that the IPO is a fair and reasonable basis on which to calculate the policyholder consideration and policy credits under the Plan. The price per share reflects the value that investors are willing to pay for the stock following informational and marketing efforts by management and underwriters, a review of the offering prospectus and other materials, consultation with industry experts and research analysts, and a comparison of the Company to comparable companies and alternative investment opportunities as well as taking into account other relevant financial considerations."

Id. at 27.

> "I find that the IPO is a fair and reasonable method of determining the value of the policyholder consideration, both individually and in the aggregate, and the participation of the Division's financial Consultants[12]

[12] In *State Mutual* (but not in the current matter, as far as we can determine from the record), the commissioner retained oversight in the IPO process. State Mutual signed a letter of agreement providing that the commissioner's advisors would be permitted to monitor the IPO process; the commissioner monitored the pricing of the stock; and the

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> will insure that the pricing process will be conducted in an open manner, consistent with industry practice."

Id. at 30.

We read the commissioner's decision in the matter at hand as having implicitly adopted her findings in *State Mutual* that the IPO was a "fair and reasonable method of determining the value of the policyholder consideration." Thus, the commissioner's overall finding of fairness is supported by substantial evidence in the record. See *Aetna Cas. & Sur. Co. v. Commissioner of Ins.*, 408 Mass. 363, 373, 558 N.E.2d 941 (1990) ("the commissioner's implicit adoption of the findings [s]he made in [her earlier] decision was [not] impermissible"). Cf. *Zachs v. Department of Pub. Utils.*, 406 Mass. 217, 221, 547 N.E.2d 28 (1989) (in making finding on public convenience and necessity, department of public utilities could rely on finding made in prior department decision regarding benefits of increased competition in radio paging market).

3. *Allocation among policyholders – "historic-plus" versus "historic-only" formula.* Approximately eighty percent of the consideration distributed to eligible policyholders (the

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underwriting agreement could not be signed unless State Mutual had complied with the letter of agreement.

In the instant matter, the commissioner's legal advisor, in its "preliminary list of issues," suggested that the commissioner should exercise a similar degree of oversight. The plaintiffs made no complaint about any lack of oversight on the part of the commissioner, although they did complain that John Hancock's advisor in the IPO process had a conflict of interest.

so-called "variable component")[13] was determined using the historic-plus methodology, which, the commissioner explained, "takes into account each policyholder's past contribution to [the mutual insurance company's] surplus as reflected on its most recent annual financial statement, and a projection of that policyholder's future contribution to surplus." The same methodology had been used in the *State Mutual* case and, the commissioner found, "in every major United States demutualization since 1990."

The plaintiffs argue that the commissioner violated the requirement of § 19E(3) that the allocation formula be "fair and reasonable" when she approved JHM's use of the historic-plus formula, and that, in any event, § 19E(3) requires use of the historic-only formula, which considers only policyholders' past contributions to surplus.

a. *Fairness.* In a footnote to their brief, the plaintiffs argue that, by factoring in expected future contributions to surplus under the historic-plus formula, the plan favored larger, more recent policyholders. Neither JHM nor the commissioner disputes this assertion. However, the commissioner noted that, "[b]ecause the aggregate consideration is constant, any change in the method of allocation would necessarily provide more consideration to some policyholders and less to others." The commissioner cited her earlier decision in *State Mutual,* in which she concluded, "[A]ny method of allocation necessarily favors some policyholders over others. . . . The requisite standard

[13] The other twenty percent of the consideration (the "fixed component") was comprised of seventeen shares of stock for each eligible policy, or the equivalent in cash or policy credits, in order to compensate policyholders for the cancellation of their right to vote.

under Section 19E[1] is that the Plan be 'not prejudicial' to policyholders, i.e., policyholders as a group. Applying this standard of review to the entire policyholder population requires the Commissioner to harmonize the competing interests of individual policyholders. Therefore, simply because a method of allocation favors some policyholders over others (as do both the historic only and the historic plus prospective methods) does not compel the conclusion that the method is prejudicial to policyholders." *State Mutual, supra* at 48.

The commissioner credited the testimony of JHM's expert, who opined that the historic-plus methodology was "intrinsically fair" and "the only basis that is intellectually supportable as fair." The commissioner further found that his opinion was supported by the 1999 Actuarial Standards Board Exposure Draft as well as the SOA Task Force Report, which stated that the historic-only methodology was "not a useful method," that the task force did not believe the historic-only method "produce[d] a theoretically correct measure of policyholder contributions, in the aggregate or policy-by-policy," and that allocation of policyholder consideration should be "based primarily on the relative contributions of policyholders to the surplus of the company" and such contributions should include both past and anticipated contributions to surplus. The historic-plus method was also endorsed by Tillinghast-Towers Perrin, the actuarial firm retained by the commissioner to review the plan's proposed allocations to eligible policyholders. Tillinghast advised the commissioner that JHM's "use of the contribution principle is consistent with the precedent set in prior U.S. demutualizations," and that, "[a]lthough the allocation of the variable component was based solely on historic contributions to surplus in two of

the earlier, less significant U.S. demutualizations, historic plus prospective contributions have been used in the more recent conversions."

The commissioner found that the evidence offered by the plaintiffs did not refute the conclusion that the allocation formula was fair and reasonable. Even their witness (Hunt) had testified that the plan was not unfair to policyholders as a group. Hunt, the commissioner found, merely testified that he believed the historic-only method was more fair, that use of the historic-plus methodology in other demutualizations did not make it more fair, and that he did not understand how the authors of the SOA Task Force Report had determined that the historic-only method would penalize most of the current individual policyholders.

In reviewing the commissioner's decision concerning a choice of methodology, we "give due weight to [her] experience, technical competence, specialized knowledge, and discretionary authority. Deference to the commissioner's expertise and discretion is particularly appropriate when reviewing her choice of methodology." *Automobile Ins. Bureau of Mass. v. Commissioner of Ins.*, 430 Mass. 285, 296, 718 N.E.2d 830 (1999) (citations omitted). As the challenging party, the plaintiffs did not carry their burden "to demonstrate that the decision of the commissioner was incorrect."[14] *Bankers Life & Cas. Co. v. Commissioner of Ins.*, 427 Mass. 136, 138-139, 691 N.E.2d 929 (1998).

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[14] The plaintiffs' further argument that the commissioner's approval of the plan effected an unconstitutional taking also fails, as the commissioner's approval of the plan, which had already been

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b. *Required use of historic-only formula.* The plaintiffs next argue that both the legislative history of the statute and the text of § 19E(3) require the use of the historic-only formula.

Section 19E(3) provides, in pertinent part:

> "[S]uch [demutualization] plan shall give each eligible policyholder appropriate consideration. Said consideration shall be determinable under a fair and reasonable formula approved by the commissioner, and *shall be based upon the insurer's entire surplus* as shown by the insurer's financial statement most recently filed with the Commissioner . . . but . . . *without taking into account the value of nonadmitted assets or insurance business in force.*"

(Emphasis supplied.)

The plaintiffs first point to the 1985 demutualization of the Union Mutual Life Insurance Company in Maine, under a statutory provision similar to § 19E(3), where the historic-only formula was approved. See Plan of Recapitalization and Conversion of Union Mutual Life Insurance Company, Final Decision and Order (Aug. 8, 1986) (*Union Mutual*). However, as the commissioner found in her decision, the insurance commissioner in *Union Mutual* ruled only that the Maine statute *permitted* use of the historic-only approach to apportion consideration among policyholders, not that such an approach was *required.* The Maine commissioner ruled:

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approved by the majority of policyholders, did not constitute State action. See *Tancredi v. Metropolitan Life Ins. Co.*, 316 F.3d 308 (2d Cir.2003).

> "[The conversion statute] permits the relative apportionment of the policyholders' equity in a mutual insurer based solely upon statutory surplus and requires, at a minimum, an aggregate distribution to eligible policyholders equal to an insurer's statutory surplus. [*Union Mutual, supra* at 8.] . . . Although the contribution to surplus principle permits other approaches . . . I find that it is not inappropriate for the Plan to use contribution to statutory surplus."

Id. at 19.

Indeed, in an analysis of the language in H. 390, the House bill that ultimately became § 19E(3), the Legislature's Joint Commission on Insurance commented that the methodology approved by the Maine commissioner in *Union Mutual* "may not be 'appropriate consideration' in every case. It will depend on the financial condition and post-conversion prospects of the reorganized insurer."

The commissioner adopted her findings in *State Mutual,* interpreting the statute's text "shall be based upon the insurer's entire surplus," as referring to the aggregate consideration, rather than the allocation to individual policyholders. This is in accord with the Maine commissioner's interpretation in *Union Mutual,* noted in the Legislature's Joint Commission on Insurance report on H. 390, that the statute "requires, at a minimum, an aggregate distribution to eligible policyholders equal to an insurer's statutory surplus." In *State Mutual* at 46-47 n.32, the commissioner examined the language of numerous earlier demutualization statutes, finding that they "required that policyholder consideration be 'based upon *not less than* the insurer's entire surplus,'" suggesting that "the purpose of the 'based upon' language is to ensure that not less than the entire surplus of a company is given

to eligible policyholders, and, therefore, requires that aggregate consideration, as opposed to allocation of consideration, be based upon the insurer's entire surplus." The plaintiffs have made no argument that the aggregate compensation was based on less than JHM's entire surplus.

Moreover, even if the term "based upon" did apply to allocation of consideration, the commissioner observed that the statute does not require that consideration be based "*only* upon the insurer's entire surplus." We agree. If the Legislature had intended such a result, "it presumably would have provided for it with some clarity." *Commonwealth v. Brown,* 431 Mass. 772, 775, 730 N.E.2d 297 (2000). Thus, the statute leaves to the commissioner's discretion the allocation of consideration among policyholders under a "fair and reasonable formula," which we have already addressed. See section 3(a), *supra.*

Last, the plaintiffs argued to the commissioner that the statute's exclusion of "nonadmitted assets" and "insurance business in force," "prohibits the reliance upon business plan projections, good will, and future profits, and thus precludes the use of the historic-plus methodology." The commissioner adhered to her decision in *State Mutual,* where she interpreted this language in the statute to mean that nonadmitted assets and insurance business in force must be excluded from the surplus upon which policyholder consideration is calculated, and found that this proviso was complied with in the demutualization plan.[15] As

[15] Since the commissioner, throughout her decision, adopted her findings in *State Mutual,* we assume that the omission of a specific finding in the John Hancock decision that the value of nonadmitted

(Continued on following page)

this interpretation comports with the statute's plain meaning, and the commissioner's interpretation is entitled to substantial deference, there is no reason to disturb it. See *Dube v. Contributory Retirement Appeal Bd.*, 50 Mass.App.Ct. 21, 23-24, 733 N.E.2d 1089 (2000), and cases cited.

4. *"Closed block."* Although not required by § 19E,[16] the plan provided for the creation of a "closed block," a mechanism, the commissioner explained in her decision, designed "to protect the reasonable policy dividend expectations of individual policyholders with certain dividend-paying policies or contracts." A closed block segregates the assets and policies therein from the rest of the newly capitalized public company, thus protecting them from market forces.

The plaintiffs complained to the commissioner that, as proposed in the plan, the closed block was not sufficiently funded. The commissioner found, however, that the plaintiffs produced no evidence to support this contention; the plaintiffs' sole witness on the issue stated that he was not an expert on closed block matters. Moreover, the plan requires Hancock to satisfy its closed block obligations out of the company's general funds, should the closed block funding be insufficient. In addition, the plan provides for ongoing monitoring of the closed block by the commissioner. The plaintiffs, therefore, have failed to provide

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assets and insurance business in force was in fact excluded, as required by the statute, was merely an oversight on her part.

[16] Some demutualization statutes require the creation of a closed block in order to protect policyholders. See *UNUM Corp. v. United States*, 130 F.3d at 505 n. 5.

evidence sufficient to overcome the commissioner's finding that the "composition, funding, and proposed operation of the Closed Block are fair, reasonable, and not prejudicial to the policyholders or to the insuring public."

In their complaint to the Superior Court, the plaintiffs argued for the first time that the plan's use of a closed block violated their contractual rights because the segregation of their interests would deprive them of the benefits of any cost-cutting or expense reductions in the company that otherwise could result in increased dividends. Now, for the first time on appeal, the plaintiffs argue that this alleged contractual violation, in turn, constituted a violation of § 19E. Since the latter argument was not raised in the Superior Court, it is waived. *Wynn & Wynn, P.C. v. Massachusetts Commn. Against Discrimination,* 431 Mass. 655, 674, 729 N.E.2d 1068 (2000).

Even were we to consider the merits of the argument, it would fail, as there was no contract violation. Each member's policy states that "the proportion of divisible surplus accruing upon this policy shall be ascertained annually," and that the policy "will be entitled to the share, if any, of the divisible surplus as the Company shall annually determine and apportion to it." The policies do not promise the members that the assumptions on which the dividend expectations are based will never change. See generally *White Fuel Corp. v. Liberty Mut. Ins. Co.,* 313 Mass. 165, 168-169, 46 N.E.2d 548 (1943). Furthermore, the plaintiffs have not made us aware of any authority to support their claim.

5. *Dismissal of the common-law and statutory claims.* In counts II through IX, the plaintiffs sought declaratory relief against the Hancock defendants, alleging breach of

contract and breach of fiduciary duty. In count X, the plaintiffs alleged violations of G.L. c. 93A. The defendants moved to dismiss these counts pursuant to Mass.R.Civ.P. 12(b)(1) and (6), 365 Mass. 755 (1974). Relying on his rulings on count I (the c. 30A claim), the judge treated the motion as one for summary judgment and allowed it.

We agree with the judge that the "claims in [c]ounts II through X are really nothing more than indirect challenges to the [c]ommissioner's [d]ecision." In this case, the contract, fiduciary duty, and c. 93A claims were inextricably intertwined with the c. 30A claim, and could not be decided "without application of the commissioner's specialized knowledge." *Liability Investigative Fund Effort, Inc. v. Medical Malpractice Joint Underwriting Assn.,* 409 Mass. 734, 748, 569 N.E.2d 797 (1991) (*LIFE*).

The contract claims (counts II-VII) allege that the conversion from mutual to publicly-held corporation violated JHM's charter, and that particular features of the Hancock conversion (e.g., closed block, historic-plus methodology) violated both the charter and the provisions of members' individual policies. However, by enacting the conversion statute, the Legislature effectively superseded the provisions of the charter and individual policies. Indeed, the JHM charter was itself created by legislation, see St. 1862, c. 125, which provided that the corporation would be "subject to . . . all other [legislative] acts which are or may be in force relative to such companies." Thus, absent a claim that the conversion statute itself violated their rights, the plaintiffs must focus their contract claims on alleged violations of § 19E. See *Municipal Light Co. of Ashburnham v. Commonwealth,* 34 Mass.App.Ct. 162, 171, 608 N.E.2d 743, cert. denied, 510 U.S. 866, 114 S.Ct. 187,

126 L.Ed.2d 146 (1993), quoting from *New Orleans Waterworks Co. v. Louisiana Sugar Ref. Co.,* 125 U.S. 18, 30, 8 S.Ct. 741, 31 L.Ed. 607 (1888) (impairment of contract clause in United States Constitution concerns "the legislative power of the State, and not . . . [the] decisions of its courts, or the acts of administrative or executive boards or officers, or the doings of corporations or individuals").

The plaintiffs' allegations that particular features of the conversion plan violated their individual policies are merely reiterations of the objections raised in the administrative proceeding.[17] The breach of fiduciary duty claim (count VIII), reduced to its essence, alleges that the conversion plan was unfair to members. This question was, of course, addressed in great detail by the commissioner, as the conversion statute charged her with determining that the plan was "fair and reasonable" before she could approve it. Thus, adjudication of both the fiduciary duty claim and the contract claims is "dependent on the substance of the commissioner's determinations during the [administrative] proceedings." *LIFE,* 409 Mass. at 748, 569 N.E.2d 797. The claims were thus properly dismissed. *Ibid.*

As to the c. 93A claim (count X), for the most part, it too boils down to an assertion that the policyholders were not adequately compensated or that the company's charter or members' policies were violated. See our discussion, *supra.* In addition, the complaint asserts that the information

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[17] Likewise, count IX of the complaint, which alleges a violation of the conversion statute, has already been disposed of in count I, the c. 30A appeal.

packet – provided by JHM to its members as a basis for the members' vote on whether to approve the plan – was misleading, insufficient to allow members to cast an informed vote, and designed to induce a positive vote. (It may be recalled that the plan was approved by 93.72 percent of the votes cast.)

It appears from the record that the plaintiffs complained to the commissioner about the adequacy of the information packet, and that she addressed their criticisms in her decision, finding that the packet was not misleading. We note in particular the commissioner's responses to the plaintiffs' complaints regarding the adequacy of the packet's disclosures concerning the percent of policyholders who would receive cash as opposed to stock in the conversion; the specifics of the anti-takeover provision; and policyholders' entitlement to compensation even if they voted against the plan.

The commissioner was correct in noting that § 19E "does not specify the scope of the notice or information that an insurer seeking to demutualize must provide to its policyholders." However, the commissioner is not without experience in determining whether information disseminated by an insurance company is misleading or contains misrepresentations. See G.L. c. 176D. Here, because the commissioner's determinations with respect to the particulars of the information packet disclosures are so intertwined with her statutory mandate to determine whether the plan is fair, reasonable, and nonprejudicial, we conclude that deference to the experience and expertise of the commissioner in these circumstances is appropriate and the c. 93A claim was properly dismissed. Compare *Murphy v. Administrator of the Div. of Personnel Admn.*, 377 Mass. 217, 221, 386 N.E.2d 211 1979), quoting from 3 Davis,

Administrative Law § 19.01, at 5 (1958) (the court "should not act upon subject matter that is peculiarly within the agency's specialized field without taking into account what the agency has to offer"); *Nader v. Allegheny Airlines, Inc.*, 426 U.S. 290, 304, 96 S.Ct. 1978, 48 L.Ed.2d 643 (1976), quoting from *Far East Conference v. United States,* 342 U.S. 570, 574-575, 72 S.Ct. 492, 96 L.Ed. 576 (1952) ("review by the judiciary . . . more rationally exercised, by preliminary resort for ascertaining and interpreting the circumstances underlying legal issues to agencies that are better equipped than courts by specialization, by insight gained through experience, and by more flexible procedure"). Cf. *J. & J. Enterprises, Inc. v. Martignetti,* 369 Mass. 535, 541, 341 N.E.2d 645 (1976) (stay of court proceedings in c. 93A action appropriate pending administrative action in matter involving agency's expertise); *LIFE,* 409 Mass. at 751, 569 N.E.2d 797 (ordinarily, where there is overlapping jurisdiction between the commissioner and the Superior Court, the court action should be stayed pending action by the commissioner); *Frank J. Linhares Co. v. Reliance Ins. Co.,* 4 Mass.App.Ct. 617, 622, 357 N.E.2d 313 (1976) (court may refer c. 93A allegations to Commissioner of Insurance "for initial determination whether an unfair practice has been committed"). The plaintiffs have cited no authority, and we find none, to suggest that deference to the agency decision in these circumstances is in error.[18]

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[18] Given the conclusions we have reached concerning counts II-X, there is no need to address the plaintiffs' contentions that the trial judge erred in converting the motion to dismiss into a motion for summary judgment.

As the plaintiffs sought declaratory relief in counts II-IX, the judgment with respect to those counts is modified to provide that the plaintiffs are not entitled to the relief they seek. As to counts I and X, the judgment is affirmed.

So ordered.

APPENDIX B

Supreme Judicial Court for the
Commonwealth of Massachusetts
One Beacon Street, Third Floor,
Boston, Massachusetts 02108
(617) 557-1020

Atty. Michael P. Malakoff
Malakoff, Doyle & Finberg, P.C.
200 Frick Building
Pittsburgh, PA 15219

RE: Docket No. FAR-13575

THOMAS TIERNEY & another
vs.
JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY & others

Suffolk Superior Court No. SUCV2000-00087
A.C. No. 2001-P-0435

NOTICE OF DENIAL OF F.A.R. APPLICATION

Please take note that on 10/03/03, the above-captioned Application for Further Appellate Review was denied.

Susan Mellen, Clerk

Dated: October 3, 2003

To: John Roddy, Esquire
Stuart T. Rossman, Esquire
Douglas H. Wilkins, Esquire
Atty. Michael P. Malakoff
Atty. Paul Benton Weeks, III
John G. Fabiano, Esquire
Thomas A. Barnico, A.A.G.
Atty. Edwin G. Schallert

APPENDIX C

Supreme Judicial Court for the
Commonwealth of Massachusetts
1412 Courthouse, Boston, Massachusetts 02108
(617) 557-1020

Atty. Michael P. Malakoff
Malakoff, Doyle & Finberg, P.C.
200 Frick Building
Pittsburgh, PA 15219

RE: No. DAR-11856

THOMAS TIERNEY & others
vs.
JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY & OTHERS

NOTICE OF DENIAL OF D.A.R. APPLICATION

Please take note that the above-captioned Application for Direct Appellate Review has been considered by the Court (Ireland, J., recused) and is denied.

Susan Mellen, Clerk

Dated: June 7, 2001

To: Stuart T. Rossman, Esquire
Atty. Michael P. Malakoff
Atty. Paul Benton Weeks, III
Peter A. Spaeth, Esquire
Peter T. Wechsler, A.A.G.
Atty. Edwin G. Schallert

APPENDIX D

2000 WL 33223223

Superior Court of Massachusetts.

Thomas TIERNEY et al.[1]

v.

John HANCOCK MUTUAL LIFE INSURANCE COMPANY et al.[2]

No. 00-0087 BLS.

Dec. 18, 2000.

MEMORANDUM OF DECISION AND ORDER ON THE PARTIES' CROSS MOTIONS FOR JUDGMENT ON THE PLEADINGS AND ON THE HANCOCK DEFENDANTS' MOTION TO DISMISS

VANGESTEL.

This matter is before the Court on the parties' cross motions for judgment on the pleadings and on the motion

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[1] Doris G. Marah, individually and on behalf of other similarly situated policyholders of John Hancock Mutual Life Insurance Company.

[2] John Hancock Financial Services, Inc.; John Hancock Life Insurance Company; the following Directors of John Hancock Mutual Life Insurance Company – Stephen L. Brown, Foster L. Aborn, David F. D'Alessandro, Samuel W. Bodman, III, Joan T. Bok, I. MacAllister Booth, Wayne A. Budd, John M. Connors, Jr., Robert E. Fast, Edward H. Linde, Dr. Kathleen Foley Feldstein, Nelson S. Gifford, Michael C. Hawley, E. James Morton, Richard F. Syron and Robert J. Tarr; the following former Directors – Lawrence K. Fish, William L. Boyan, John F. Magee and Chester V. Vappi; and Hon. Linda Ruthardt, Commissioner of Insurance. Except for Commissioner Ruthardt, all of the parties named in this note, along with the John Hancock Mutual Life Insurance Company, are collectively referred to herein as the "Hancock defendants."

of the Hancock defendants to dismiss the amended complaint (hereafter the "complaint"). In Count I, plaintiffs seek judicial review pursuant to G.L.c. 30A, § 14(7) of a decision by Massachusetts Insurance Commissioner Linda Ruthardt ("Commissioner") approving the plan (the "Plan") of John Hancock Mutual Life Insurance Company ("JHM") to convert from a privately held mutual insurance company to a publicly traded stock company. Plaintiffs, who are policyholders and ex-members of JHM, argue that in approving the conversion plan, the Commissioner failed to provide them with just compensation for their ownership and property rights in JHM. The plaintiffs seek to have the entire conversion plan set aside. Specifically, plaintiffs allege that the Commissioner erred in her interpretation and application of G.L.c. 175, § 19E, the Massachusetts mutual insurance company conversion law ("§ 19E"). All defendants respond that they are entitled to judgment on the pleadings because plaintiffs have failed to satisfy the G.L.c. 30A, § 14(7) requirements for a Court to set aside or modify an administrative agency decision.

The complaint also includes claims against the Hancock defendants for breach of contract (Counts II through VII); breach of fiduciary duty (Count VIII); violation of G.L.c. 175, § 19E (Count IX); and violation of G.L.c. 93A (Count X). The Hancock defendants have filed a motion to dismiss these counts of the complaint pursuant to Mass.R.Civ.P. Rule 12(b)(1) and (6), arguing that plaintiffs have no standing to bring them, that plaintiffs failed to exhaust their administrative remedies with regard to the issues raised, and that the complaint is moot.

For the following reasons, plaintiffs' motion for judgment on the pleadings is *DENIED* and the Commissioner's

motion for judgment on the pleadings on Count I is *ALLOWED*. Accordingly, plaintiffs' additional claims for relief against the Hancock defendants – based principally on the Commissioner's approval of the demutualization Plan – are without merit. Thus, the Hancock defendants' motion to dismiss is *ALLOWED* also.

THE ADMINISTRATIVE RECORD

The Massachusetts demutualization statute permits a mutual life insurance company to convert to a stock life insurance company. The law requires that the conversion plan be approved by the Commissioner of Insurance as "not prejudicial to the policyholders . . . or the insuring public" and as providing "appropriate consideration" to each eligible policyholder in exchange for relinquishment of rights in the mutual company which is being converted. G.L.c. 175, § 19E(1) and (2).

In 1998, JHM informed the Commissioner of its intent to convert from a privately held mutual insurance company, owned and controlled by its policyholders, to a publicly held corporation. Pursuant to § 19E, the Commissioner authorized a working group (the "Working Group") consisting of Division of Insurance (the "Division") staff members and outside consultants to review all of JHM's proposals on behalf of policyholders and the general public. The Division also retained outside legal, actuarial, accounting and financial experts to provide the Working Group with independent advice and assistance in evaluating the Plan. The actuarial firm of Tillinghast-Towers Penn reviewed the provisions regarding allocations to eligible policyholders and the maintenance of reasonable policyholder dividend expectations; the accounting firm of

Pricewaterhouse Coopers LLP conducted a financial due diligence examination and monitored policyholder voting procedures and JHM's preparations and procedures for providing notice; the investment banking firm of Wasserstein Perella & Co., Inc. reviewed the fairness of the consideration for eligible policyholders as a group; and the law firm of Stroock & Stroock & Lavan reviewed the Plan's compliance with § 19E. The Working Group examined proposed drafts of the Plan and made recommendations for improvements to JHM and its advisors.

On August 31, 1999, JHM management adopted the conversion Plan and, pursuant to § 19E, submitted it to the Commissioner for approval. The Plan called for JHM to become a subsidiary of a holding company, providing eligible policyholders with stock, cash or policy credits in exchange for their interests in the mutual company. Those interests were the right to vote at JHM's annual and special meetings and the right to share in the distribution of the residual value of JHM in the event of a solvent liquidation. These interests are essentially illiquid. The formula adopted by JHM for allocating consideration among its policyholders utilized the so-called "historic plus" methodology, including both fixed and variable components. The fixed component compensated policyholders for the loss of their right to vote regardless of the level of their contribution to JHM's surplus; the variable component, which comprised the majority of the consideration, allocated additional shares to reflect each policyholder's past and projected future contributions to the surplus.

The Commissioner appointed two attorneys as co-Presiding Officers for the public hearing mandated by § 19E. Neither the Commissioner nor the Presiding Officers

participated in the Working Group's analysis of the Plan. The Commissioner instructed all members of the Working Group not to comment on or discuss the Plan with the Presiding Officers. The Commissioner then issued the required notice of public hearing, which was published nationally and mailed to millions of JHM policyholders, employees and others. The Commissioner received numerous written submissions in response to the notice.

On November 17 and 18, 1999, the Commissioner and the two appointed Presiding Officers conducted a public hearing on the Plan. Both plaintiffs submitted written materials; plaintiff Thomas Tierney ("Tierney") spoke at the hearing, as did the attorney for plaintiff Doris Marah ("Marah"). The record of the hearing was left open until November 22, 1999, for additional public comment.

Section 19E requires that policyholders vote to approve a conversion plan. On December 3, 1999, following a November 30, 1999, special meeting of policyholders, JHM reported that 93.72% of the 3,425,977 votes cast by approximately 1.1 million policyholders were in favor of the Plan.

Section 19E also requires the Commissioner to determine that the Plan be not prejudicial to JHM's policyholders or to the insuring public.[3] On December 9, 1999, the

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[3] On August 2, 1995, in a similar matter involving State Mutual Life Assurance Co. of America, the Commissioner determined that the requirement that the Plan not be prejudicial to policyholders applied to policyholders as a group, and that the Commissioner was "required to harmonize the competing interests of individual policyholders," not to determine whether the plan was in the best interests of each and every policyholder, which was considered an impossible standard.

Commissioner issued a decision (the "Decision") approving the Plan pursuant to the requirements of § 19E. The Decision, which was based on a review of all the evidence presented to the Commissioner, including the concerns raised by policyholders, presented a detailed discussion of the Plan's compliance with § 19E. The Decision directly addressed specific policyholder concerns about the allocation of consideration.

On January 7, 2000, plaintiffs challenged the Plan, arguing that it did not adequately protect their interests as policyholders because it did not provide them with "just compensation" for their financial interests in the mutual company. Specifically, plaintiffs assert: (1) that the Plan's use of an initial public offering ("IPO") of stock with anti-takeover provisions significantly undervalued plaintiffs' shares; (2) that the Commissioner erred in applying the "historic plus" formula to determine the value of policyholders' shares; and (3) that the Commissioner exceeded her statutory powers by approving a "closed block"[4] conversion that allowed the new insurance company to operate members' insurance contracts as "participating" rather than "nonparticipating."

In her December 9, 1999, Decision, the Commissioner specifically addressed these concerns, finding: (1) that there was "no merit" in plaintiffs' contention that policyholders were proprietary owners of the company; (2) that the Plan provided "each eligible policyholder with 'appropriate

[4] The "closed block" portion of the agreement protects the policy dividend expectations of certain policyholders from the vagaries of the market forces after the capitalization.

consideration' in exchange for their membership interests"; (3) that the Plan's use of the "historic plus" formula was fair and reasonable; and (4) that the proposed operation of the Closed Block was fair and reasonable and not prejudicial to policyholders or the insuring public.

Plaintiffs argue that the decision should be remanded because the Commissioner's approval of the Plan was based on an erroneous construction of § 19E. The Commissioner has issued only one other decision applying § 19E. *See State Mutual Life Assurance Co. of America,* ("State Mutual"), Executive Office of Consumer Affairs, Division of Insurance, Docket No. F-95-1 (August 2, 1995).[5] The plaintiffs claim that some of the decisions made in *State Mutual* were erroneous, and that the Commissioner therefore erred in relying on any of those decisions in this matter.[6]

DISCUSSION

Cross Motions for Judgment on the Pleadings

Judicial review of the Commissioner's findings is basically an appeal governed by G.L.c. 30A, § 14. Claims filed in the Superior Court seeking judicial review of administrative agency proceedings must be resolved through a motion

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[5] Tierney also testified in those proceedings on behalf of three named policyholders who were unavailable to testify.

[6] In *State Mutual,* for example, the compensation to policyholders was determined by an IPO, and consideration was determined on an "historic plus" basis. That plan was not appealed, under the conditions of an August 25, 1995, Settlement Agreement entered into by State Mutual with the Center for Insurance Research and certain policyholders.

for judgment on the pleadings. *See* Superior Court Modified Standing Order 1-96; Mass.R.Civ.P. Rule 12(c). Such judicial review is confined to the administrative record, and the Court may modify or set aside an agency decision only if the agency has made an error that prejudices the appealing party's substantial rights.[7]

In an appeal pursuant to G.L.c. 30A, § 14, the effective appellants, here the plaintiffs, bear the burden of demonstrating a decision's invalidity. *Coggin v. Massachusetts Parole Board,* 42 Mass.App.Ct. 584, 587, 678 N.E.2d 1206 (1997); *Merisme v. Bd. of App. on Motor Veh. Liab. Policies and Bonds,* 27 Mass.App.Ct. 470, 474, 539 N.E.2d 1052 (1989). In reviewing the Decision here, the Court is required to give due weight to the Commissioner's experience, technical competence, specialized knowledge and the discretionary authority conferred upon her. *Flint v. Commissioner of Public Welfare,* 412 Mass. 416, 420, 589 N.E.2d 1224 (1992).

The Court must confine its review to the administrative record, *Cherubino v. Board of Registration of Chiropractors,* 403 Mass. 350, 354, 530 N.E.2d 151 (1988), and sustain the Commissioner's Decision unless it is unsupported by substantial evidence. *Solimeno v. State Racing Commission,* 400 Mass. 397, 509 N.E.2d 1167 (1987);

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[7] The Court may set aside or modify an agency decision that is: in violation of constitutional provisions; in excess of statutory authority or jurisdiction of the agency; based upon an error of law; made upon unlawful procedure; unsupported by substantial evidence; unwarranted by the facts found by the agency on the record as submitted; or arbitrary and capricious, an abuse of discretion or otherwise not in accordance with law. G.L.c. 30A, § 14(7).

Hotchkiss v. State Racing Commission, 45 Mass.App.Ct. 684, 695-696, 701 N.E.2d 642 (1998); *Yazbek v. Bd. of App. on Motor Veh. Liab. Policies and Bonds,* 41 Mass.App.Ct. 914, 916 (1996). In other words, to the extent the Commissioner's ruling is one of fact, it stands if supported by substantial evidence. *Dohoney v. Director of the Div. of Employment Sec* 377 Mass. 333, 337 n. 3, 386 N.E.2d 10 (1979); *Buckley v. MCAD,* 20 Mass.App.Ct. 172, 175, 478 N.E.2d 1292 (1985). "Substantial evidence means such evidence as a reasonable mind might accept as adequate to support a conclusion." G.L.c. 30A, § 1(6); *see Lycurgus v. Director of the Div. of Employment Sec.,* 391 Mass. 623, 627-28, 462 N.E.2d 326 (1984).

The Court may not receive additional evidence, absent the special circumstances set forth in G.L.c. 30A, § 14(5), which do not exist here. Nor is the judicial review a trial *de novo. Southern Worc. Cty. Reg. Voc. Sch. Dist. v. Labor Relations Comm'n,* 386 Mass. 414, 420, 436 N.E.2d 380 (1982). The Commissioner is the sole judge of the weight to be afforded to the evidence before her. *Guarino v. Director of the Div. of Employment Sec.,* 393 Mass. 89, 92, 469 N.E.2d 802 (1984). It is "within the [Commissioner's] discretion to disbelieve the [appellants'] version . . . " *Yazbek, supra,* 41 Mass.App.Ct. at 916, 670 N.E.2d 200.

> The judge does not properly act as a fact finder . . . The [Commissioner] alone functions as the finder of facts . . . The judge's function . . . is to determine whether [she] applied correct legal principles in reaching [her] decision. *Guarino, supra,* 393 Mass. at 92, 469 N.E.2d 802. Thus, the decision of the Commissioner must be affirmed if it is supported by substantial evidence on the record as a whole, taking into account whatever in the record fairly detracts from its

> weight. G.L.c. 30A, § 14(7); *Cohen v. Board of Registration in Pharmacy,* 350 Mass. 246, 253, 214 N.E.2d 63 (1966).

G.L.c. 30A, § 14(7), however, authorizes a Court to set aside, modify or remand an administrative decision if it determines "that the substantial rights of any party may have been prejudiced because the agency decision is based on an error of law."

Here, plaintiffs allege that because JHM's conversion Plan inadequately compensated them for giving up their ownership rights in the mutual company, the Commissioner's approval of the Plan exceeded her authority and constituted an unconstitutional taking of plaintiffs' property. Plaintiffs argue that the Commissioner erred as a matter of law because the Plan's determination of "appropriate consideration" was prejudicial to policyholders. Plaintiffs contend that they were prejudiced by the Plan's reliance on an IPO with anti-takeover provisions and by the Plan's utilization of the "historic plus" formula.

Since judicial review of the Commissioner's Decision is confined to the administrative record, the Court may "not make a de novo interpretation of the facts or draw different inferences from the [Commissioner]." *Vaspourakan Ltd. v. Alcoholic Beverages Control Commission,* 401 Mass. 347, 351, 516 N.E.2d 1153 (1987). G.L.c. 175, § 19E(1) requires that a plan approved by the Commissioner must conform "to the requirements of this section." Thus, the first task for this Court is to determine whether, based on the administrative record, the Plan approved by the Commissioner conformed to the requirements of § 19E.

Certain subsections of the statute set forth specific procedural requirements:

> that a public hearing be conducted and that proper notice of the hearing be given to the insurer, its directors, officers, employees and policyholders, all of whom shall have the right to appear and be heard (subsection 1);
>
> that the plan be approved by a vote of not less than two-thirds of the insurer's policyholders voting in person, by proxy or by mail at a meeting called for that purpose pursuant to such reasonable notice and procedures as may be approved by the commissioner (subsection 2);
>
> that the plan give each eligible policyholder a preemptive right to acquire his proportionate part of all of the proposed capital stock, (subsection 4);
>
> that shares be offered to policyholders at a price not greater than thereafter offered to others under the plan (subsection 6); and
>
> that the plan provide for payment to each policyholder of consideration (subsection 7).

The administrative record reflects that the Plan complied with all of these statutory requirements. Review of the Commissioner's Decision indicates that she acted in all respects in accordance with these procedural directives. The Commissioner authorized a Working Group including Division staff and outside consultants to review JHM's proposals, involving legal, accounting, financial and actuarial experts; she conducted a public hearing and provided proper notice of that hearing; the Plan was approved by substantially more than two-thirds of JHM voting policyholders; policyholders had a choice of receiving cash, stock or premium discounts for their interests; stock was offered to policyholders at a price not greater

than that offered to others; and the Plan provided for payment of consideration to each policyholder.

In addition to these procedural requirements, certain subsections of the statute entrust evaluative judgments to the discretion of the Commissioner. Thus, pursuant to subsection (1), the Commissioner must determine that a proposed plan is "not prejudicial to the policyholders of such company or to the insuring public." In addition, subsection (3) requires the Commissioner to ensure that policyholders receive "appropriate consideration" for their membership interests in the company, "determinable under a fair and reasonable formula approved by the Commissioner." These discretionary judgments are challenged by the plaintiffs.

In reviewing the Decision, "the [C]ourt shall give due weight to the experience, technical competence, and specialized knowledge of the [Commissioner], as well as to the discretionary authority conferred upon [her]." G.L.c. 30A, § 14(7). If, however, the reviewing Court determines that the Decision was based upon an error of law, the Court may refuse to support it. *See Van Munching Co. v. Alcoholic Beverage Control Comm'n,* 41 Mass.App.Ct. 308, 310-11, 670 N.E.2d 401 (1996), where the Court recognized its obligation to give "due weight to the [ABCC's] experience, technical competence and specialized knowledge, as well as to the discretionary authority conferred upon it."

In *Van Munching,* however, the language of the statute specifically prohibited discounts with a discriminatory purpose, so the Court found that the statute did not give the ABCC the discretion to determine whether a non-discriminatory discount was otherwise fair or reasonable. Here, in contrast, G.L.c. 175, § 19(E) gives the Commissioner

very broad discretion in deciding whether or not a proposed demutualization plan is fair. The Commissioner is, in fact, charged with determining whether or not a proposed demutualization plan is "prejudicial" to policyholders or to the insuring public and whether the plan provides policyholders with "appropriate consideration" for their membership interests, based on "a fair and reasonable formula." Thus, the statute specifically grants the Commissioner the discretion to evaluate the overall fairness of a proposed plan. This case, therefore, clearly is distinguishable from *Van Munching,* in which the Court found that the ABCC's decision contradicted the plain language of the statute. Here, where the Commissioner exercised discretion explicitly granted to her by G.L.c. 175, § 19E, this Court finds no error of law.

The plaintiffs also maintain that the Commissioner abused her discretion in finding that the Plan provided them with appropriate consideration for their interests in the mutual company. First, they argue that the Commissioner's reliance on an IPO containing anti-takeover provisions to determine the value of plaintiffs' interests unfairly depressed the value of those interests. Second, they contend that the statute prohibited the Commissioner from relying on the "historic plus" methodology, asserting that the wording of § 19E(3) required the use of the "historic only" formula. Finally, they challenge the Plan's provisions regarding the operation of the Closed Block.

IPO with Anti-takeover Provisions

Where the use of an anti-takeover provision is specifically authorized by § 19E(9), the decision to couple such a

provision with an IPO falls squarely within the Commissioner's discretion under the statute.[8] This Court must defer to the Commissioner's interpretation of her statutory mandate, as long as the interpretation is plausible. *See LeBeau v. Dept. of Employment and Training,* 422 Mass. 533, 537, 664 N.E.2d 21 (1996). In reviewing the Commissioner's Decision under G.L.c. 30A, the Court must determine whether that Decision is supported by substantial evidence – "such evidence as a reasonable mind might accept as adequate to support a conclusion." *New Boston Garden Corp. v. Board of Assessors of Boston,* 383 Mass. 456, 466, 420 N.E.2d 298 (1981). It makes that determination here. The amount of evidence before the Commissioner was far more than adequate to support her conclusions.

Historic Plus Allocation

Plaintiffs challenge the use of the "historic plus" method to allocate consideration to policyholders, arguing that the wording of the statute prohibits the inclusion of any criteria based on estimates of future experience. The statute states:

> In exchange for all membership interests in the company, such plan shall give each policyholder appropriate consideration. Said consideration shall be determinable under a fair and reasonable formula approved by the commissioner, and

[8] Plaintiffs acknowledge that § 19E(9) authorizes the use of an antitakeover provision in a demutualization plan, because such a provision protects shareholders by preventing a third party from acquiring the company at an artificially low price.

> shall be based upon the insurer's entire surplus as shown by the insurer's financial statement most recently filed with the commissioner . . . including all voluntary reserves but excluding contingently repayable funds and outstanding guaranty capital shares at the redemption value thereof, and without taking into account the value of nonadmitted assets or insurance in force.

G.L.c. 175, § 19E(3).

Plaintiffs contend that this language required the Commissioner to utilize the "historic only" methodology, which bases the allocation to policyholders on a company's surplus on a specific day before the conversion. Plaintiffs argue that because the statutory language excludes the value of "insurance in force," the Commissioner improperly approved the use of a formula that included estimated future contributions to surplus. Plaintiffs contend that the Commissioner did not have the statutory discretion to approve just any fair and reasonable formula, but only a formula based on historic criteria.

"Where the Legislature has not imposed specific restrictions on the reasonable methods by which an agency may carry out its mandate in the plain language of the agency's enabling statute, it is not appropriate for the courts to order the agency to follow specific methods for meeting the agency's mandate." *Mass. Coalition for the Homeless v. Sec'y. of Health & Human Services,* 422 Mass. 214, 223, 661 N.E.2d 1276 (1996), quoting *Williams v. Sec'y. of Executive Office of Human Servs.,* 414 Mass. 551, 570, 609 N.E.2d 447 (1993). A Court may not tell a person in the Commissioner's position how to fulfill her legal obligation unless "there is but one way in which the

obligation may properly be fulfilled." *Matter of McKnight,* 406 Mass. 787, 792, 550 N.E.2d 856 (1990). Where the plain language of the statute does not mandate that the Commissioner utilize a particular methodology to determine appropriate consideration, the decision of which allocation formula to use was within the Commissioner's discretion, and that discretion was properly exercised here.

Closed Block

The plaintiffs suggest that the Closed Block, as funded under the Plan, may not meet policyholders' dividend expectations. The Commissioner found, however, that plaintiffs failed to introduce evidence to support this assertion. The Closed Block included almost all individual policies that would receive dividends after the demutualization. The premiums paid under those policies would be credited to the Closed Block, and all benefits and dividends would be paid out of the Closed Block. To the extent that these assets were insufficient to pay benefits guaranteed under the Closed Block, the Plan provided that JHM satisfy these obligations out of its general funds. Moreover, the Plan provides for the Commissioner's ongoing monitoring of the operation of the Closed Block to ensure that policyholders' expectations are met.

If a Court finds that an agency decision is based on sufficient evidence, the "court may not displace an administrative board's choice between two fairly conflicting views, even though the court might justifiably have made a different choice had the matter been before it *de novo.*" *Vaspourakan. Ltd. v. ABCC, supra,* 401 Mass. at 351, 516 N.E.2d 1153. Here, the Commissioner had the statutory

authority to determine whether the Plan provided policyholders with "appropriate consideration," and the record reflects that her determination on this point was based on substantial evidence. The Commissioner's Working Group of Division staff and outside financial, actuarial and legal consultants reviewed JHM's proposals for her. These experts, most of whom were independent, evaluated the very Plan provisions that are now being challenged by the plaintiffs, including the reasonableness and fairness of the allocations to policyholders and the adequacy of the Closed Block provisions. In her Decision, the Commissioner discussed the different points of view presented on these issues, and explained in some detail the reasons for her decisions, including the resultant benefits to policyholders.

Where the Commissioner had the discretionary authority to determine whether JHM's proposed Plan provided policyholders with appropriate compensation and where that decision was supported by substantial evidence, this Court may not substitute its judgment for that of the Commissioner.

The Commissioner's Decision was supported by substantial evidence, was warranted by the facts presented to and found by her, and was neither based on an error of law nor was it arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law.

The Remaining Counts of the Complaint

Whatever the outcome on Count I, the plaintiffs argue that they nevertheless are entitled to proceed to trial on the remaining counts against the Hancock defendants. These are the claims for breach of contract, breach of

fiduciary duty and violation of G.L.c. 93A. This Court disagrees.

Before reaching the issues argued as to these counts, the Court pauses to discuss a procedural nuance. The Hancock defendants have moved to dismiss these counts pursuant to Mass.R.Civ.P. Rule 12(b)(1) and (6). In considering their motion, this Court places substantial reliance upon its own determination of Count I, after its judicial review of the administrative record under G.L.c. 30A, § 14(7), pursuant to Mass.R.Civ.P. Rule 12(c). Whether that reliance, at least for Rule 12(b)(6) purposes, requires treating the Hancock defendants' motion to dismiss as one for summary judgment under Rule 56 is not entirely clear. *See*, e.g., *Watros v. Greater Lynn Mental Health & Retardation Association, Inc.*, 421 Mass. 106, 108-09, 653 N.E.2d 589 (1995). Nor, however, to this Court does it seem of much moment. Certainly, the parties here were not taken by surprise with the Hancock defendants' contentions that the determination of Count I in the Commissioner's and their favor would have a dismissing effect on the remaining counts. Neither at the oral arguments on November 21, 2000, nor at any time since, have the plaintiffs raised any procedural or other issues suggesting that they needed or required any additional opportunity to present material of a different nature should this Court's actions result in the Hancock defendants' motion to dismiss being disposed of under Rule 56 rather than Rule 12(b)(6). Consequently, this Court sees no need for any further notification of its intent to do so. *See*, e.g., *Gomes v. Metropolitan Property & Casualty Insurance Company,* 45 Mass.App.Ct. 27, 32, 695 N.E.2d 673 (1998).

The Court, therefore, turns now to the substance of the motion.

In general, it is too late to raise a claim before a reviewing Court if the point was not raised before the administrative agency. *See McCormick v. Labor Relations Comm'n,* 412 Mass. 164, 170, 588 N.E.2d 1 (1992); *Albert v. Municipal Court,* 388 Mass. 491, 493, 446 N.E.2d 1385 (1983); *Gordon & Son, Inc. v. Alcoholic Beverages Control Commission,* 386 Mass. 64, 69, 434 N.E.2d 986 (1982). The plaintiffs do not deny a failure to present to the Commissioner claims that the Plan breached JHM's Charter or policyholders' contracts, that JHM's management breached their fiduciary duties, or that management's devising and implementing the Plan violated c. 93A.

Here, in any event, the Commissioner already has addressed essentially all of the issues raised in the additional counts. The breach of contract counts are based on plaintiffs' allegations that (1) because the JHM Charter did not authorize a conversion from a mutual insurance company to a publicly held corporation, the Plan breached JHM's Charter and failed to protect policyholders' contractual ownership rights, and (2) the Closed Block arrangement failed to compensate policyholders adequately for their interests in JHM. Similarly, the claims for breach of fiduciary duty and violation of c. 93A are grounded on plaintiffs' same charges that the conversion violated the Charter and that the "historic plus" formula and Closed Block arrangements deprived policyholders of adequate compensation for their interests in JHM. The claims in Counts II through X are really nothing more than indirect challenges to the Commissioner's Decision.

Each of these underlying claims was considered and rejected by the Commissioner; each was discussed in some detail in her Decision; and the Commissioner's actions have now been found appropriate by this Court. Where reasonable minds differ as to the action an agency should take, the Court must defer to the informed judgment and experience of the agency. *See Massachusetts General Hospital v. Weiner,* 569 F.2d 1156, 1159 (1st Cir.1978).

It is not "a reasonable canon of interpretation that the draftsmen of acts delegating agency powers, as a practical and realistic matter, can or do include specific consideration of the evil sought to be corrected." *Id.* For this reason, the legislature relies on the expert's familiarity with industry conditions. *Id.* Here, there is no question that the conversion statute raised significant issues of fairness that required a careful balance of competing interests. "The historical conflict in demutualization has been the competing interests of the current management, or 'insiders,' and the interests of the policyholders." Arthur J. Chartrand, Associate Counsel, National Association of Insurance Commissioners, *Demutualization* 3 (1985).

> Conversion, however, is not an easy process. There is a practical and almost inherent conflict of interest between the mutual company and its management, and the rights and interests of the policyholders themselves. Balancing the interests of the company with fair and equitable treatment to all policyholders while controlling any overreaching or undue advantage by management or third parties is at the crux of the problem.

Id.

Chartrand makes it clear that, in the demutualization process, there is no consensus on how companies are to be

valued or how the allocation to policyholders is to be made. He suggests, however, that "if disinterested third parties come up with a figure they think is fair, the commissioner agrees, and the policyholders by super-majority vote agree, a fair result, while not guaranteed, may be achievable." *Id.*

Here, the Commissioner was assisted in her evaluation of the Plan by outside independent actuarial, accounting, financial, and legal consultants, each of high repute. Her process complied with the statutory requirements of proper notice, a public hearing, and a special vote open to all policyholders. The policyholders who voted approved the Plan by more than 93%.

Thus, because all of the arguments underlying the claims against the Hancock defendants were addressed by the Commissioner's decision, and because the Commissioner properly acted in rejecting those arguments, the claims against the Hancock defendants may not be subject to further judicial review. *See*, e.g., *Harhen v. Brown,* 431 Mass. 838, 848, 730 N.E.2d 859 (2000) (in shareholders' derivative action, management is entitled to the protection of business judgment rule in absence of any allegation of bad faith).

The Hancock defendants converted JHM from a privately held mutual insurance company to a publicly traded stock company. The law of Massachusetts permitted that conversion, provided that the Plan be approved by the Commissioner of Insurance pursuant to G.L. 175, § 19E. This Court has found that the Commissioner properly approved of the Plan. Further, over 93% of the voting policyholders also approved of the Plan. In connection with this Commissioner-approved conversion, it cannot then be said that the Hancock defendants breached

contractual obligations or fiduciary duties,[9] violated G.L. 175, § 19E, or committed unfair and deceptive acts or practices prohibited by G.L.c. 93A.

ORDER

For the foregoing reasons, it is hereby *ORDERED* that plaintiffs' motion for judgment on the pleadings is *DENIED* and defendants' motion for judgment on the pleadings is *ALLOWED*. Further, the Hancock defendants' motion to dismiss, treated as a motion for summary judgment because of the Court's reliance upon its own rulings on Count I, is also *ALLOWED*. Judgment is to enter accordingly.

[9] Count VIII also suffers from a failure to satisfy the special pleading requirements for a derivative claim under Mass.R.Civ.P. Rule 23.1.

APPENDIX E

Division of Insurance

John Hancock Plan of Reorganization Decision

Docket No. F-99-04

Proposed Plan of Reorganization of John Hancock Mutual Life Insurance Company

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DECISION

I. INTRODUCTION

John Hancock Mutual Life Insurance Company ("Hancock") has filed a Plan of Reorganization ("Plan") with the Division of Insurance ("Division"), seeking to convert from a mutual life insurance company to a stock life insurance company pursuant to Section 19E of chapter 175 of the Massachusetts General Laws ("§ 19E"). As the basis for its decision to pursue demutualization, Hancock's Board of Directors determined that reorganization as a stock company would allow Hancock to raise capital to grow its existing businesses and develop new business opportunities, to use stock as currency with which to make acquisitions, and to be able to attract and retain key management personnel.

Under § 19E, both the policyholders and the Commissioner of Insurance ("Commissioner") must approve the Plan before it may take effect. The affirmative vote of two-thirds of the votes cast by policyholders eligible to vote is required to approve the Plan. The Commissioner must hold a hearing on the Plan at which the insurer, its directors, officers, employees, and policyholders have the right

to appear and be heard. Following the hearing, the Commissioner must determine whether the Plan conforms to the requirements of § 19E and is not prejudicial to Hancock's policyholders or the insuring public. Hancock is the second Massachusetts mutual life insurance company to file a reorganization plan under § 19E. On August 2, 1995, the Commissioner approved a plan of reorganization filed by State Mutual Life Assurance Company of America. *Plan of Reorganization of State Mutual Life Assurance Company of America, Findings of Fact, Conclusions of Law and Order*, DOI Docket No. F-95-1 ("*State Mutual*").

If the Plan is approved, Hancock will change its name to John Hancock Life Insurance Company and it will become a wholly-owned stock subsidiary of John Hancock Financial Services, Inc., a newly formed Delaware holding company ("JH Financial"). In exchange for their interests in the mutual company, eligible policyholders will receive compensation in the form of cash, policy credits, or stock in JH Financial. Hancock contemplates completion of an initial public offering ("IPO") of common stock in JH Financial in early 2000. Hancock expects to list the common stock of JH Financial on the New York Stock Exchange under the symbol "JHF." The demutualization will not reduce existing policy or annuity contract benefits, guarantees, values or dividend rights, all of which will remain in full force and effect. In addition, the Plan includes a Closed Block mechanism that will be funded to protect the reasonable policy dividend expectations of individual policyholders with certain dividend-paying policies or contracts.

II. PROCEDURAL HISTORY

In November 1998, the Commissioner, pursuant to § 19E, authorized a Working Group of Division staff members and outside consultants, headed by Julie M. Bowler, First Deputy Commissioner ("Working Group"). The Commissioner charged the Working Group with reviewing on behalf of Hancock policyholders and the insuring public, all of Hancock's proposals. As part of the Working Group, the Division retained outside legal, actuarial and financial experts to provide the independent advice and assistance in evaluating the Plan. Specifically, the Division retained: 1) the actuarial firm of Tillinghast-Towers Perrin ("Tillinghast"), to review the Plans provisions regarding the maintenance of reasonable policyholder dividend expectations, and allocations to eligible policyholders; 2) the accounting firm of PricewaterhouseCoopers LLP ("Pricewaterhouse") to conduct a financial due diligence examination and to monitor Hancock's procedures for preparation and mailing of the package of information to policyholders, and to monitor the policyholder voting procedures; 3) the investment banking firm of Wasserstein Perella & Co., Inc. ("Wasserstein") to review, from a financial perspective, the fairness of the consideration for eligible policyholders as a group; and 4) the law firm of Stroock & Stroock & Lavan LLP ("Stroock") to review the Plan's compliance with § 19E. The Working Group extensively reviewed proposed drafts of the Plan and made numerous recommendations to Hancock and its outside advisers for improvement to the Plan.

The Commissioner appointed Sharon S. Kamowitz, Esq., and Richard A. Cody, Esq., as co-Presiding Officers for the hearing on the Plan. Neither the Commissioner nor the Presiding Officers participated in the Working Group's

analysis of the Plan. Further, the Commissioner instructed all members of the Working Group and others at the Division to maintain a strict policy of not commenting on or discussing the Plan with the Presiding Officers.

The Hancock Board of Directors adopted the Plan on August 31, 1999; Hancock immediately filed the Plan with the Commissioner.

On September 1, 1999, the Commissioner issued a Notice of Public Hearing ("Notice of Hearing" or "Notice") pursuant to the Administrative Procedures Act, G.L. c. 30A and the Formal Rules of the Standard Rules of Practice and Procedure, 801 C.M.R. 1.01 *et seq.*, subject to such modifications as are permitted by law. The Notice scheduled a public hearing to begin on November 17, 1999, and scheduled pre-hearing conferences for October 19 and November 15, 1999. The Notice offered an opportunity for any person to file a written statement concerning the Plan, or to submit a notice of intent to make an oral statement at the hearing. The Notice stated that any person who desired to intervene or participate in the hearing, other than by making a written or oral statement, was required to submit a written request by October 4. The Notice also stated that a copy of the Plan and all of its exhibits was available for inspection at the Division and at Hancock's main office, and that the Plan was posted on the websites of the Division and Hancock.

The Notice of Hearing was published in The Boston Globe, The Worcester Telegram & Gazette, The Springfield Union News, The Berkshire Eagle, The New York Times (National Edition), and USA Today (National Edition) on September 2, 1999. Between September 8 and 15, Hancock mailed a postcard to eligible policyholders informing them

of the proposed demutualization, and advising them to watch their mail for a package of information. The postcard also advised policyholders that they could obtain information through a toll-free telephone number, on Hancock's website, and in a public document room at the Division. Between September 19 and 30, Hancock mailed to eligible policyholders a demutualization package consisting of Policyholder Information Statement, Parts I and II ("PIS"); and Information Guide; and a four-part Policyholder Record, Ballot, Taxpayer Identification, and Cash/Stock Compensation Card. Since September 2, 1999, the policyholders and members of the public have had access to extensive materials related to the demutualization at the Division's public document room and at Hancock's offices.

On September 22, the Presiding Officers ordered Hancock to respond to all letters to the Division submitted by policyholders regarding the Plan, and to file a copy of each response. On October 7, 1999, pursuant to G.L. c. 175, § 206B(e), the Commissioner issued an Order granting a request filed by Hancock on August 13, 1999, for an exemption from the provisions of G.L. c. 175, § 206B(a).[1]

Petitions to intervene were filed by Mutual of America Life Insurance Company ("MOA"); Loretta M. Harhen, Aaron E. Landy, Jr., and the John S. Katzman Family Trust

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[1] G.L. c. 175, § 206B(a) provides that "no person shall . . . acquire control of a domestic insurer or any person controlling a domestic insurer unless, at the time of such [transaction], such person has filed with the commissioner . . . a statement containing the information required by this section and such [transaction] has been approved by the commissioner in the manner [prescribed by this section].

(collectively, "Named Policyholders"), and the Center for Insurance Research, Inc. ("CIR"), and the Brett M. Davis Trust ("Davis Trust"). Hancock filed written oppositions to each petition.

A hearing on the petitions to intervene was held on October 14, 1999. The Presiding Officers orally issued their rulings at the October 19, 1999, pre-hearing conference. The petitions of MOA and CIR were denied in their entirety.[2] The petitions of the Named Policyholders and the Davis Trust were also denied. However, the Named Policyholders and the Davis Trust (collectively, "Participants") were granted participant status in accordance with 801 CMR 1.01(9)(e). As specified in that regulation, participation status carries the rights to submit an *amicus* brief and to argue orally at the close of the hearing. In addition, the Presiding Officers allowed the Participants to offer relevant testimony of previously identified expert witnesses, and to submit written questions, which the Presiding Officers, in their discretion, could to [sic] ask Hancock's witnesses. The Participants were directed to coordinate their evidentiary presentations so as to avoid repetition. On October 27, 1999, the Presiding Officers issued a written memorandum and order setting forth the basis for these rulings.[3]

On November 1, 1999, Hancock filed written direct testimony of its witnesses, Stephen L. Brown, Hancock's

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[2] A request by Hancock that the Commissioner order MOA to resolve its dispute with Hancock through arbitration was also denied as beyond the scope of the hearing.

[3] The full procedural history relating to the petitions to intervene is set forth in that order.

Chairman and Chief Executive Officer; Godfrey Perrott, F.S.A., M.A.A.A., a consulting actuary of Milliman & Robertson; Derek G. Kirkland, Managing Director and co-head of the Global Insurance Group of Morgan Stanley Dean Witter ("Morgan Stanley"); and John M. DeCiccio, Senior Vice President of Hancock. Hancock also submitted exhibits for the hearing. On November 8, 1999, the Participants submitted written direct testimony of their witnesses as well as the exhibits to be introduced at the hearing.[4] The Participants' original list of witnesses included David Schiff, the editor and writer of *Schiff's Insurance Observer*, an independent insurance industry newsletter; James Hunt, an actuary, and former Vermont Commissioner of Banking and Insurance; William Feeley, a Managing Director and Head of Capital Markets of Wit Capital Corporation; and Robert Mendelson, a Senior Vice President and Co-general Counsel of Wit Capital Corporation.

On November 10, 1999, the Participants submitted questions they proposed be directed to Hancock witnesses. On November 12, 1999, Hancock submitted its pre-hearing memorandum. A final pre-hearing conference was held on November 15, 1999. At that conference, the Participants submitted their pre-hearing memorandum as well as additional proposed questions for Hancock's witnesses. Hancock filed objections to the Participants' proposed

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[4] The Participants' submissions, as well as their pre-hearing and post-hearing briefs were filed by counsel for the Named Policyholders "in cooperation with" the Davis Trust. This Decision, in discussing the issues raised by the Participants, identifies the policyholder(s) that raised each issue based on the claims made in the petitions to intervene.

questions. In addition, the Participants advised the Presiding Officers that William Feeley and Robert Mendelson had withdrawn their testimony. The Division subsequently received formal notices of withdrawal from Mr. Feeley and Mr. Mendelson, dated November 12, 1999.

The Commissioner and the Presiding Officers conducted the public hearing on November 17 and 18, 1999. Edwin G. Schallert, Esq., of Debevoise & Plimpton, and Bruce E. Skrine, Esq., and James Marchetti, Esq., Hancock's Deputy General Counsel and Senior Counsel, respectively, appeared as counsel for Hancock.[5] Jason B. Adkins, Esq., and Paula Isola, Esq. of Adkins & Kelston, P.C., appeared on behalf of the Named Policyholders. Michael F. Pezzulli, Esq. of Pezzulli & Loewinsohn, LLP, appeared as counsel for the Davis Trust.

Stephen L. Brown presented an opening statement on behalf of Hancock. Following Mr. Brown's opening statement, a number of policyholders and other persons offered comment on the Plan. The Secretary of State of the Commonwealth, William F. Galvin, also made a statement. Counsel for the Named Policyholders and the Davis Trust offered oral statements on behalf of their clients.

Following public comment on the Plan, each of Hancock's previously identified witnesses, Stephen L. Brown, Derek G. Kirkland, Godfrey Perrott, and John M. DeCiccio adopted his pre-filed testimony under oath and presented an oral statement. The Commissioner and the Presiding

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[5] Judith Taft, Esq., and Eileen E. Sullivan, Esq., of Debevoise & Plimpton, and Marylou Fierro, Esq. of Hancock, also represent Hancock.

Officers questioned these witnesses on issues relating to the requirements of § 19E and concerns raised by policyholders.

On November 18, 1999, the Participants presented the testimony of David Schiff and James Hunt. These witnesses adopted their pre-filed testimony under oath. Following direct testimony, Hancock cross-examined the Participants' witnesses, and counsel for the Named Policyholders conducted re-direct examination.

All exhibits offered by Hancock and the Participants were admitted into evidence. In addition, written reports and opinions of Tillinghast, Wasserstein, Pricewaterhouse, and Stroock were received in evidence.

At the conclusion of the hearing, counsel for the Named Policyholders and Hancock delivered closing arguments. The record of the hearing was left open until November 22, 1999, for additional public comment. Hancock was ordered to continue to respond to letters submitted to the Division by policyholders, and to supplement the evidentiary record with these letters and Hancock's responses.[6] On November 23, 1999, Hancock and the Named Policyholders filed post-hearing briefs. On November 24, 1999, we granted Hancock's motion to supplement the record with additional

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[6] The record was also left open for Hancock's filing of an exemption from Section 406(a) of the Employee Retirement Income Security Act of 1974 and Section 4975 of the Internal Revenue Code. Mr. DeCiccio testified that the exemption had been published in the Federal Register, and that Hancock expects to receive the exemption from the United States Department of Labor before the Plan becomes effective. That it has not been received as of the date of this Decision does not affect our conclusions regarding the Plan.

information. On the same day, the Named Policyholders submitted a supplemental post-hearing statement in response to that motion.

On December 3, 1999, following the November 30, 1999, Special Meeting of Policyholders, Hancock reported that 93.72 percent of the 3,425,977 votes cast by approximately 1.1 million policyholders were in favor of the Plan.

III. ANALYSIS OF THE PLAN

Section 19E requires the Commissioner to determine that the Plan satisfies certain requirements. In addition, she must find that the Plan is not prejudicial to Hancock's policyholders or the insuring public. In *State Mutual*, the Commissioner determined that the requirement that the Plan not be prejudicial to policyholders applies to policyholders as a group, and that the Commissioner is, therefore, required to "harmonize the competing interests of individual policyholders." In other words, she need not determine that the Plan is in the best interests of each and every policyholder, a standard that would be impossible to attain.

We will first discuss the specific statutory requirements and issues related to those provisions raised by policyholders. We will then consider the more general issues relating to the determination of whether the Plan, as a whole, is prejudicial to policyholders and the insuring public.

A. Specified Requirements of Section 19E

1. Section 19E(1) – Filing of the Plan and Notice Requirements

Section 19(E)(1) requires that the Plan be filed with the Commissioner and that notice of the hearing on the Plan be "given to the insurer, its directors, officers, employees and policyholders, all of whom shall have the right to appear and be heard at the hearing." The Administrative Procedure Act, which governs the conduct of this hearing, requires that such notice be reasonable and that it sufficiently apprise recipients of the issues involved to afford them a reasonable opportunity to prepare and present evidence and argument. G.L. c. 30A, §§ 10 and 11.

Section 3.2(a) of the Plan requires that Hancock mail or deliver notice of the hearing to persons entitled to appear and the be heard under § 19E at least 30 days prior to the hearing, except in instances where the Commissioner has determined that mailing is not feasible.

In their petition to intervene, the Named Policyholders alleged that the notice to policyholders was deficient, not reasonable, and prejudiced their interests and ability to seek intervention, to retain and prepare witnesses, and to prepare their presentation.[7]

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[7] They also argued that policyholders were prejudiced by the fact that Hancock's informational forums were held only in Massachusetts, and that they were conducted after the deadline for policyholders to seek intervention. In our October 27, 1999, Memorandum and Order on

(Continued on following page)

In addition, they argued that they were prejudiced by what they characterize as an "expedited time frame" between issuance of the Notice of Hearing and the November 17, 1999, public hearing. The Named Policyholders did not pursue these arguments in their pre-hearing or post-hearing briefs or at the hearing. Nor do they specifically contend that the Plan does not meet the requirements of § 19E(1).

As discussed above, Hancock filed the Plan with the Commissioner, and the Commissioner issued the Notice of Hearing on September 1, 1999. The Notice was published in four Massachusetts newspapers and two newspapers of national circulation on September 2, 1999. The Notice also was posted on the websites of Hancock and the Division during the first week of September 1999. It was also mentioned by Hancock in a postcard mailed to eligible policyholders between September 8 and 15, 1999, and was included in the policyholder information package mailed by Hancock to eligible policyholders between September 19 and 30, 1999. Hancock and the Division also made early drafts of the Plan available on their websites beginning in November 1998. In addition, the public documents rooms located both at the Division and at Hancock's headquarters

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Petitions to Intervene, we addressed the arguments regarding sufficiency of the notice for purposes of seeking intervention. We note that § 19E does not require informational forums, and that Hancock conducted these forums at the suggestion of the Working Group.

have been open and available to the public during normal business hours since September 2, 1999. We note further that the approximately sixty-day notice was given further in advance of the notice that the Commissioner found to be reasonable in *State Mutual*.

We conclude that the Plan meets the requirements of § 19E(1), and, in addition, that the notice to Hancock, its directors, officers, employees, and policyholders, and the time frame during which these proceedings occurred were reasonable, sufficient, not prejudicial, and afforded a reasonable opportunity to prepare and to present evidence and argument.

B. Section 19E(2) – Policyholder Vote

Section 19(E)(2) requires that the Plan be "approved by vote of not less than two-thirds of the votes of the insurer's policyholders voting thereon in person, by proxy or by mail at a meeting of policyholders called for that purpose." In addition, it requires that the policyholder vote must be upon "such reasonable notice and procedure as may be approved by the commissioner."

The Plan meets this requirement. Section 4.1 of the Plan provides that the Plan "is subject to the approval of not less than two-thirds of the votes of the Voting Policyholders voting thereon in person, by proxy or by mail at the Special Meeting." The Special Meeting of Policyholders was held on November 30, 1999, pursuant to notice that was issued concurrent with the Notice of

Hearing. The final vote count shows that 93.72 percent of the 3,425,977 votes cast by approximately 1.1 million policyholders were in favor of the Plan. In addition, we find that the notice of the vote and the procedures for voting were reasonable.

C. Section § [sic] 19E(2) – Allocation of Consideration

Section 19E(3) requires that "in exchange for all membership interests in the company," a plan of demutualization must provide each eligible policyholder with "appropriate consideration." In addition, it requires that the consideration be determined under "a fair and reasonable formula approved by the commissioner" and that it be "based upon the insurer's entire surplus as shown by the insurer's financial statement most recently filed with the commissioner . . . including all voluntary reserves but excluding contingently repayable funds and outstanding guaranty capital shares at the redemption value thereof, and without taking into account the value of nonadmitted assets or insurance business in force."

Section 7.1(b) of the Plan establishes two elements of consideration for eligible policyholders: a fixed component and a variable component. The fixed component, 17 shares per eligible policy, or the equivalent in cash or policy credits, is designed to compensate policyholders for the cancellation of their

right to vote.[8] The fixed component is expected to comprise approximately twenty percent of the total consideration to be distributed to eligible policyholders, and ensures that all eligible policyholders will receive a minimum amount of consideration.[9]

Under the Plan, only policies with positive actuarial contributions will share in the variable component. The amount of a policyholder's variable component was determined by a methodology that takes into account each policyholder's past contribution to Hancock's surplus as reflected on its most recent annual financial statement, and a projection of that policyholder's future contribution to surplus. In general, this manner of determining consideration is known as the historic-plus prospective methodology ("historic-plus methodology"). The Commissioner approved the use of this methodology in *State Mutual*.

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[8] The number of shares is subject to proportional adjustment under § 9.6 of the Plan.

[9] The amount of the fixed component is not related to the number of votes that are represented by a particular policy, G.L. c. 175, § 94 specifies the number of votes for each policy, depending on the type of policies owned and the amount of insurance or annual annuity income under those policies. Under this section, no policyholder is entitled to more than twenty votes. In its petition to intervene, the Davis Trust contended that it is adversely affected because it is only allowed twenty votes. The Plan's limitation on the number of votes that may be exercised in favor of or in opposition to the Plan is set by statute and is thus not prejudicial.

To carry out the calculations under this methodology, Hancock's business was first categorized into seven major product lines, each containing policies with similar characteristics.[10] Within each product line, a model was created consisting of a series of cells, which in the aggregate, replicate the degree of diversity in the product line.[11] In order to calculate the past contribution to surplus, experience factors for each cell were determined by examining the financial history of each product line on a basis consistent with the manner in which Hancock developed experience factors for pricing and dividend purposes. For the purposes of these calculations, mortality costs, morbidity costs, expense rates, investment returns, the effect of federal income taxes, and other elements were obtained or estimated for a historical period going back, in some cases, more than sixty years. These experience factors were then applied in conjunction with the policy factors applicable to each cell (such as premiums and dividends) to develop the portion of Hancock's assets, as of December 31, 1998, that is associated with the operations

[10] The seven product lines are: individual life insurance, individual annuities, individual long term care, other individual health business, group annuities, group long term care, and group life and other health insurance business.

[11] For individual policies, a cell consists of a given policy type issued to a person of a given age in a given calendar year. For group policies, a cell is either a specific policy if the policy is experience-rated or a collection of policies whose experience is pooled.

of that cell. This amount, minus the statutory liability held by Hancock, as of the same date, with respect to that cell, is the past contribution of the cell. The results were interpolated to arrive at the amount of past contribution for each eligible policy.

To determine the value of each cell's expected future contribution to surplus, experience factors for the future were estimated. For Closed Block business, because the future profit that will inure to Hancock will be determined by the assumptions used at the time the Closed Block was funded, future experience factors were estimated by using the assumptions underlying that funding, with appropriate adjustment for expenses outside the Closed Block.[12] For all other business, the assumptions underlying Hancock's business plan projection were used; the factors were projected into the future based on a continuation of the assumptions underlying the latter years of the business plan projection. The experience factors and the applicable policy factors were then applied to develop the estimated present value of future profits associated with the operation of the cell as of December 31, 1998. The results were interpolated to arrive at an estimated future contribution for each eligible policy.

[12] The Closed Block was funded as of January 1, 1999.

The Named Policyholders and a few people who offered comment regarding the Plan object to the use of the historic-plus methodology. They assert that the historic-only methodology, which takes into account only past contributions to surplus, is required by § 19E(3).

The Named Policyholders specifically claim that the requirement that the consideration "be based upon the insurer's entire surplus as shown by the insurer's financial statement most recently filed" is equivalent to a requirement that consideration be based on known, and not projected data. Therefore, they contend that § 19E(3) precludes the use of the historic-plus methodology because this methodology considers expected or estimated contributions to surplus. They point out that the statute does not reference future or estimated surplus. In addition, they contend that the language in § 19E(3) that requires consideration to be determined "without taking into account the value of nonadmitted assets or insurance business in force" prohibits the reliance upon business plan projections, and good will, and future profits, and thus precludes the use of the historic-plus methodology.

The Named Policyholders also rely on a comparison of § 19E(3) to the demutualization statutes of New York and Maine. They contend that because § 19E(3) is similar to the Maine statute, and because UNUM, a Maine insurer that demutualized in 1986, employed the historic-only methodology, such a methodology is required by § 19E(3).

Further, they rely on the testimony of their actuarial witness, James Hunt, to argue that that the historic-plus methodology used by the Plan unfairly favors newer policyholders over long-term policyholders who, they contend, contributed more to Hancock's surplus.[13] They contend further that policyholders are prejudiced by Hancock's allocation formula because many of the assumptions and data underlying the calculations have not been made available to policyholders. They also contend that the historic-plus methodology produces "strange" results that are not understandable by policyholders.

Finally, the Named Policyholders point out that Hancock's actuarial advisor, Milliman & Robertson, and its legal advisor, Debevoise & Plimpton, both of whom also advised State Mutual in connection with its demutualization, initially advised that company that § 19E(3) requires the use of the historic-only methodology, and then later changed their opinions. The Named Policyholders argue that we should ignore the Commissioner's decision in *State Mutual* because these early opinions were not publicly disclosed during the proceeding on State Mutual's plan of demutualization.

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[13] They also rely on written comments submitted by Joseph M. Belth. However, Mr. Belth was not identified as a Hancock policyholder or as a witness by the Named Policyholders, was not present at the hearing, and was not subject to questioning by Hancock or the Presiding Officers.

In addition, some policyholders, including the Davis Trust, have raised more general questions regarding the allocation methodology. Many policyholders have complained that they do not understand the basis for their allocation and that the allocation does not appear to be fair.

After reviewing the evidence presented, and carefully considering the concerns raised by policyholders, we conclude that the Plan provides each eligible policyholder with "appropriate consideration" in exchange for their membership interests in Hancock, and that the allocation of consideration under the Plan is based upon a fair and reasonable formula.

The decision in *State Mutual* approved the use of the historic-plus methodology under § 19E. The Commissioner determined that the statutory requirements for "appropriate consideration" and for a formula that is "fair and reasonable" do not demand the use of any one method of allocation, but are "consistent with a flexible, rather than a rigid, approach to allocation of policyholder consideration." She concluded that Section 19E(3) "allows for different methods to be employed, depending on the circumstances of the particular demutualization, so long as the formula employed is fair and reasonable in that instance." *State Mutual*, at 44. The decision noted that the use of the historic-plus methodology is supported by the Report of the Society of Actuaries Task Force on Mutual Life Insurance Company Conversion, published in 1987 ("SOA Report"), which states that allocation of policyholder

consideration should be "based primarily on the relative contributions of policyholders to the surplus of the company" and that such contributions should include both past and anticipated contributions. *State Mutual*, at 46. Further, the decision concluded that the phrase "based upon the insurer's entire surplus," applies to the determination of the aggregate consideration, and not to the allocation of such consideration. It noted that § 19E does not require that consideration be based *only* upon the insurer's entire surplus. *State Mutual*, at 46-47, n. 32.

We find no reason to depart from this interpretation of § 19E. Further, we find persuasive Hancock's argument that the interpretation of § 19E offered by the Named Policyholders could preclude paying policyholders a fixed component of consideration because this component, which compensates policyholders for the right to vote, is not based on Hancock's entire surplus. Hancock notes that use of the historic-only methodology would also not result in consideration exactly equal to surplus because the positive and negative contributions of former policyholders are not included in the historic calculation.

The historic-plus methodology has been used in every major United States demutualization since 1990. Furthermore, the assertion of the Named Policyholders that the decision in the UNUM demutualization required use of the historic-only method under statutory language similar to § 19E(3) is unfounded. The Legal Standards Rulings cited in that decision provided that the Maine statute *permitted* the use of an allocation

methodology based exclusively on historic contributions to surplus. *See* Final Decision and Order, *In Re Plan of Recapitalization and Conversion of Union Mutual Life Insurance Company*, at 8 (August 8, 1986).

We are not persuaded by the Named Policyholders' reliance on Milliman & Robertson and Debevoise & Plimpton memoranda that initially supported the use of the historic-only methodology under § 19E for the *State Mutual* demutualization. During his oral testimony, Mr. Perrott offered a credible explanation regarding this issue. Further, the conclusion in *State Mutual* was not dependent solely upon the opinions of either Milliman & Robertson or Debevoise & Plimpton.

As discussed above, the Commissioner's task under § 19E is to determine whether the allocation formula used by Hancock is fair and reasonable, and whether the Plan is prejudicial to policyholders and the insuring public. The record of this proceeding demonstrates that the methodology used to allocate consideration under the Plan meets these criteria.

First, Mr. Perrott testified that the allocation under the Plan has been determined under a fair and reasonable formula and results in appropriate consideration for policyholders. He stated that an allocation based on the historic-only methodology would be less fair than an allocation based on the historic-plus methodology because under the historic-only methodology, many of Hancock's policyholders who bought policies in the last ten years would be deprived

of any variable component of consideration, while owners of policies that had been in existence for a somewhat longer period of time would, on the whole, receive a disproportionate amount of Hancock's distributed value. He noted further, that while the historic-only methodology might have arguably been applicable to State Mutual, it would not be applicable to Hancock. He explained that State Mutual had virtually stopped selling individual insurance ten years before it demutualized, whereas Hancock is still actively selling participating whole life insurance policies.

Because the aggregate consideration is constant, any change in the method of allocation would necessarily provide more consideration to some policyholders and less to others. Mr. Perrott testified that although consideration could be allocated in many different ways (for example, based upon the size of the policy or how long it had been in force), an allocation based upon contributions to Hancock's value "is intrinsically fair" and is "the only basis that is intellectually supportable as fair."[14] He explained that the allocation is based on the total amount of profit that a policy is expected to contribute to Hancock, and that different policies are more or less profitable than other policies, due to, among other things, the level of competition in the marketplace. He noted specifically that

[14] Tr. 4; 162-163.

large policies are often less profitable than smaller policies.

Further, Mr. Perrott's testimony is supported by the SOA Report which states that the historic-only approach has a "serious deficiency as a conversion allocation methodology because it will produce negative contributions for most of a company's current individual policyholders." The report states further, that the historic-only methodology "is not a useful method and the Task Force does not believe it produces a theoretically correct measure of policyholder contributions, in the aggregate or policy-by-policy."[15] We note also that more recently, in May 1999, the Task Force on Allocation of Policyholder Equity of the Life Committee of the Actuarial Standards Board promulgated an Exposure Draft of Proposed Actuarial Standard of Practice, "Allocation of Policyholder Consideration in Mutual Life Insurance Company Demutualizations," which recommends use of the historic-plus methodology.

In addition, Tillinghast reviewed Hancock's allocation of policyholder consideration and, specifically, the use of the historic-plus methodology. It concluded that the method of allocation is fair and reasonable, and that the Plan is fair and not prejudicial to Hancock's policyholders or the insuring public. Wasserstein has also opined that, from a financial perspective, the Plan is fair to policyholders

[15] JHX 27 at 138.

as a group. As discussed above, the *State Mutual* decision concluded that the requirement that the Plan be not prejudicial to policyholders applies to policyholders as a group.

The evidence offered by the Named Policyholders does not refute the conclusion that the allocation formula is fair and reasonable. Although their witness, Mr. Hunt, claims that the allocation formula results are not understandable by policyholders, he testified that the Plan is not unfair to policyholders as a group.[16] In support of the Named Policyholders' claims, he stated only that: 1) he believes that the historic-only methodology is more fair to policyholders than the historic-plus methodology; 2) the use of the historic-plus methodology in other proceedings does not make it more fair; and 3) he does not understand how the authors of the SOA Report determined that the historic-only method would penalize most of a company's current individual policyholders. Mr. Hunt testified that there are valid reasons that would preclude an insurance company from disclosing the complete details of its allocation formula.

Therefore, while we are sensitive to the concern that the allocation formula as applied to eligible policies may be confusing to some

[16] He also testified that Hancock's decision to demutualize "is marvelous for current policyholders" and that he has advised Hancock policyholders "to not let their policies go because they're going to get this windfall." Tr. 5; 144, 157.

lay persons, we conclude that it complies with the requirements of § 19E(3). "[S]imply because a method of allocation favors some policyholders over others . . . does not compel the conclusion that the method is prejudicial to policyholders." *State Mutual*, at 48.

D. Section § 19E(4) – Preemptive Rights

Section 19E(4) requires that the Plan "give each eligible policyholder a preemptive right to acquire his proportionate part of all of the proposed capital stock of the insurer . . . or, without limiting the generality of the foregoing . . . the plan shall provide either (i) that no policyholder shall have any preemptive right to acquire any of the proposed capital stock of the insurer or of the proposed parent or other corporation or (ii) for preemptive rights on such other terms as approved by the commissioner." Section 9.7 of the Plan specifies that policyholders will not have preemptive rights.

The Participants and other policyholders contend that the lack of a preemptive or subscription rights offering in the Plan is unfair because they will be denied participation in any rise in Hancock's stock price.[17]

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[17] Hancock states, in its Post-Hearing Memorandum, at 49, that the policyholders seek a "subscription rights offering, a concept analogous to (and technically a subset of a preemptive rights offering)." We note that, in general, a subscription right is one granted by an issuer to its existing security holders, and that subscription rights are at the issuer's discretion. A preemptive right is a contractual, statutory

(Continued on following page)

Some of them argue, further, that they are entitled to maintain their proportional ownership in the newly created stock company. We are not persuaded that we should disapprove the Plan on this basis or that we should require Hancock to amend the plan to offer preemptive or subscription rights to policyholders.

Section 9.7 of the Plan provides that no policyholder or other person has any preemptive right to acquire shares of common stock in connection with the Plan. Mr. DeCiccio testified that most major United States demutualizations since 1990 that have provided compensation to policyholders have not included such rights, and we note that they were not required in *State Mutual*. Further, the lack of a preemptive or subscription rights offering does not deny policyholders the ability to purchase stock in JHF Financial.

Section 19E(4) does not guarantee the continuation of proportional ownership into the future. In addition, Hancock's witnesses testified that a preemptive or subscription rights offering would involve significant and costly logistical difficulties, given the approximately three million policyholders. Such an offering would delay the IPO, and would thus, potentially, negatively impact the IPO stock price,

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or charter-granted right of the shareholder to maintain the shareholders' then applicable percentage of the shares outstanding.

which could disadvantage all eligible policyholders. In addition, only a small percentage of policyholders would be likely to have the economic means and interest to participate in such an offering, which would impose costs on all policyholders.

The Participants and others offering comment have suggested that a subscription rights offering could be conducted over the internet. Mr. Kirkland, on behalf of Hancock, testified that such an offering would create logistical complexity and would only be feasible if all Hancock policyholders had access to the internet and if the terms of the IPO disclosure required to be made to potential investors did not change near the time of the IPO. In support of their suggestion, the Participants initially offered testimony of two witnesses from Wit Capital Corporation, but that testimony was withdrawn. Mr. Schiff, on behalf of the Participants, acknowledged that an internet offering would not reach all or even most policyholders and that the Securities & Exchange Commission has issued guidelines making clear that the availability of a prospectus on-line would not be sufficient disclosure for such an offering. Thus, an internet offering would not eliminate the need for mailing millions of copies of offering materials

Therefore, we conclude that the Plan complies with § 19E(4) which does not require a preemptive rights offering by Hancock. In addition, the Plan's lack of a provision for preemptive or subscription rights does not lead us to conclude that Plan is prejudicial

to Hancock's policyholders or the insuring public.

E. Section § 19E(5) – Eligible Policyholders

Section 19E(5) defines a policyholder "eligible to participate in the distribution of consideration" as

> . . . the person whose name appears on the conversion date on the insurer's records as owner of a policy under which there is a right to vote and which, on both the December thirty-first immediately preceding the conversion date and the date the insurer's board of directors first votes to convert to stock form, is in full force for its full basic benefits with no unpaid premium or consideration at the expiration of any applicable grace period, or which is being continued under a nonforfeiture benefit and continues to be eligible for participation in the insurer's annual distribution of divisible surplus.

Section 6.1-6.4, and 7.1-7.4 of the Plan define eligible policyholders as owners of a policy under which there is a right to vote and which was in force on August 31, 1999, and December 31, 1999, assuming a 2000 effective date of the Plan.[18] If the effective date occurs in 2001, the Plan provides that a policy must be in force on August 31, 1999 and

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[18] Section 5.2(a) of the Plan states that the Plan will be effective on the IPO closing date.

December 31, 2000 in order to be eligible for compensation. Any policy that is continued under a nonforfeiture benefit and is not eligible to participate in divisible surplus while in that status, is not eligible for compensation.[19]

Based on these definitions, we conclude that the Plan meets the requirements of § 19E(5).

F. Section § 19E(6)

Section 19E(6) requires that the Plan provide that "shares are to be offered to policyholders at a price not greater than to be thereafter offered under the plan to others." The Plan does not include any provision that would contradict this provision. Therefore, we conclude that the Plan meets the requirements of this section.

G. Section 19E(7) – Payment of Consideration

Section 19E(7) requires that the Plan provide for "payment to each policyholder of consideration which may consist of cash, securities, a certificate of contribution, additional life insurance or annuity benefits, increased dividends or other consideration or

[19] As Hancock notes, there is an ongoing dispute with MOA regarding Hancock's determination that MOA's contract is one of reinsurance and is not eligible for compensation. In denying MOA's petition to intervene, we determined that that dispute involves the application of the Plan, but does not raise any issue as to the validity of the Plan itself.

any combination of such forms of consideration."

Section 7.1(a) of the Plan provides that eligible policyholders will receive shares of common stock in JH Financial, cash or policy credits in exchange for their membership interests.[20] Section 7.3(a)(vii) of the Plan requires that policyholders who desire stock instead of cash must affirmatively elect to receive stock by checking off a box on the Cash/Stock Compensation card. Absent such an election, policyholders are assumed to prefer cash compensation. Additionally, Section 7.3(b) of the Plan provides that policyholders who receive cash or policy credits will be entitled to a "top-up" mechanism by which their compensation will be computed as a multiple of the greater of the price per share at which the stock is offered to the public in the IPO, or the average of the closing price of the stock for the first 20 days of

[20] In order to preserve their tax status, the following types of contracts and policies will be eligible solely for policy credits: individual retirement annuity contracts qualified under § 408(b) of the Internal Revenue Code, individual tax sheltered annuity contracts qualified under § 403(b) of the Internal Revenue Code, individual annuity contracts issued directly to a plan participant pursuant to a tax qualified plan under § 401(a) of the Internal Revenue Code, and individual life insurance policies issued directly to a plan participant pursuant to a tax qualified plan under § 401(a) of the Internal Revenue Code. Unless they are eligible for policy credits, the following policies will be eligible solely for cash; policies subject to a creditor's lien (other than a policy loan made by Hancock) or bankruptcy proceeding; policies for which the mailing address of the policyholder is outside the Untied States, and its territories and possessions; and policies for which the mailing address is one at which mail is undeliverable.

trading after the IPO, subject to a cap of 120 percent of the IPO price.

The funds to pay cash to those who do not elect stock will be allocated from the funds raised by Hancock in the IPO and any other transaction described in § 5.2(g) of the Plan. Section 7.3(d) of the Plan describes a set of priorities that will be used to distribute cash consideration in the event that there is insufficient cash to distribute to all policyholders electing to receive cash. Hancock estimates that it will be able to honor cash preferences for policyholders who were allocated up to 65 shares. Mr. DeCiccio testified that default to cash provisions were employed by Guaranty Mutual, Mutual of Canada, and The Equitable Life Insurance Company in their respective demutualizations.

For policyholders who will own fewer than 100 shares of stock, § 7.3(f) of the Plan provides a commission-free sales and purchase program that allows such shareholders either to buy, at prevailing market rates, the number of shares necessary to reach 100 shares, or to sell all of their shares, without incurring brokerage commissions, mailing charges, registration fees, or other administrative expenses. Mr. Kirkland testified that if and when a shareholder decides to sell his or her stock, it is easier and cheaper, and the trade execution better, to trade in so-called "round lots" such as 100-share blocks than it is to trade odd numbers of shares, or "sub-round lots" of stock.

The Named Policyholders claim that the default to cash provision is unfair and prejudicial because, they claim, policyholders with a share allotment of fewer than 65 shares are automatically defaulted to cash, while those whose allotment exceeds that number will automatically be defaulted to stock. They further contend that the Plan and PIS are misleading and prejudicial to policyholders because Hancock does not disclose that approximately eighty percent of Hancock's policyholders will be cashed out, leaving the majority of ownership interests in JH Financial in the hands of institutional investors, or that policyholders receiving cash compensation will realize immediate tax consequences. Finally, these policyholders allege that the PIS and Information Guide are misleading because they do not indicate whether Hancock's board members and managers who are entitled to compensation under the Plan will elect to receive stock or cash. They do not, however, claim that the default to cash, itself, is not permitted under § 19E, or that it is prejudicial to policyholders.

We are not persuaded by their arguments. First, there is no dispute that any eligible policyholder who wants common stock has the opportunity to elect to receive that common stock. The Named Policyholders' contention that policyholders receiving fewer than 65 shares will automatically receive cash, while those receiving more than 65 shares will automatically receive stock, is simply incorrect.

In addition, Hancock has explained that it chose to have cash as the default consideration based on a review of the demographics of its eligible policyholders, many of whom own small face amount "industrial" life insurance policies.

Furthermore, the Plan's "top-up" provision is beneficial to eligible policyholders because it allows those who receive cash or policy credits to share in the benefit of any short-term appreciation in the stock price without being subjected to the down-side risk of stock ownership. We note that, according to Hancock, it is the only insurer to date to offer such a benefit in its demutualization plan.

Mr. Kirkland also testified that the annual administrative cost of servicing a shareholder is approximately $15 per shareholder. Thus, for a policyholder receiving the minimum fixed component of shares, it would cost Hancock nearly $1 per share to service that shareholder. In light of Hancock's expected earnings of $2 per share, Hancock and its financial adviser, Morgan Stanley, concluded that the expenditure of nearly half that amount in shareholder servicing costs would be excessive and not in the best interests of Hancock, its policyholders, or its shareholders. We also are not persuaded that the Plan is misleading because it fails to disclose that a certain percentage of policyholders will be cashed out. Any attempt at disclosure in the Plan or accompanying materials of the number of policyholders expected to be "cashed out" would be speculative because Hancock cannot know or reliably predict the actual

percentage of policyholders who will receive cash. This is especially true given that Hancock has disclosed to policyholders that there is only a certain amount of cash available and that some people who elect cash may have to receive stock instead.

Furthermore, we find that the tax opinion provided by Hancock's counsel discusses the various tax implications for policyholders.

Finally, the Named Policyholders have failed to show why policyholders are prejudiced because the PIS did not disclose whether Hancock's executives and board members who are eligible policyholders under the Plan, have elected to receive cash or stock as their compensation. Pursuant to the Plan, and in accordance with § 19E, for purposes of the demutualization these individuals are treated the same as any other policyholder. Therefore, they will receive only the consideration allocated to them under their respective policies, and would not have made that election prior to the distribution of the Plan to all policyholders.

We conclude that the Plan meets the requirements of § 19E(7). In addition, we find that the default to cash provision is not unfair or prejudicial to policyholders or the insuring public.

H. Section 19E(8)

Section 19E(8) requires that the Plan, when completed, must "provide for the converted insurer's paid-in capital stock to be in an amount not less than the minimum paid-in

capital stock and the net cash surplus required of a new domestic insurer upon initial authorization to transact like kinds of insurance."

The Plan meets this requirement. Section 5.2(h) of the Plan provides that "... the Company's paid-in capital stock and net cash surplus shall be equal to an amount not less than the minimum paid-in capital stock and the net cash surplus required of a new domestic stock insurer upon initial authorization to transact like kinds of insurance."

I. Section 19E(9)

Section 19E(9) requires a finding by the Commissioner that Hancock "has not, through reduction in volume of new business written, or cancellation or through any other means sought to reduce, limit or affect the number or identity of the insurer's policyholders to be entitled to participate in such plan or to otherwise secure for the individuals comprising management any unfair advantage through such plan."

The Named Policyholders claim that the Plan violates this section because the migration of life insurance business over the past decade from Hancock to its stock subsidiary, John Hancock Variable Life Insurance Company, constitutes a "de facto demutualization." The Named Policyholders allege that the number of individual life insurance policies written by Hancock "declined approximately 33 percent during the years

1989 through 1997, while the industry generally declined by 22 percent." In addition, they allege that because the Plan does not disclose the consideration which will be granted to management and directors of Hancock in the future, it is impossible to determine whether the Plan secures for them an unfair advantage.

The Named Policyholders have not produced evidence to support their allegation that the shift in business constituted an intentional effort by Hancock to affect policyholders' participation in the Plan. Mr. DeCiccio testified that after Hancock's Board of Directors voted to pursue demutualization, Hancock instituted a series of procedures to ensure that policyholders seeking to terminate their policies received notice of the possibility of demutualization and the potential loss of consideration before becoming ineligible. Further, the Division's legal adviser reviewed those procedures and confirmed that the migration over time to variable and universal life insurance business did not entail a prohibited purpose and was consistent with the overall shift in the life insurance market to equity products.

We are also not persuaded that Hancock's management has sought to secure an unfair advantage. Sections 9.2 and 9.3 of the Plan prohibit the acquisition of JH financial shares by Hancock's officers and directors, and the compensation of its officers, directors, agents and employees for aiding, promoting or assisting in connection with the transactions

contemplated by the Plan. Section 7.1 prohibits the allocation or payment of consideration for any policy issued to an officer or director that was not in force on or before May 10, 1998, the day that the Board of Directors announced its intention to pursue demutualization. Disclosure of any future compensation would be speculative.

Therefore, we find that the Plan complies with § 19E(9).

J. Other Requirements of § 19E

a. *Anti-Takeover Provisions*

Section 19E provides that a conversion plan may include "provisions restricting the ability of any person or persons acting in concert from directly or indirectly offering to acquire or acquiring the beneficial ownership of ten percent or more of any class of common stock of the converted insurer or the parent corporation or other corporation."

Section 9.4 of the Plan states that: 1) no person or entity may directly or indirectly offer to acquire or acquire ten percent or more of the common stock of the holding company or of the stock of Hancock until two years after the IPO; and 2) during the third year following the IPO, no such acquisition of the stock of the holding company or of Hancock may be made without the prior approval of the holding company's Board of Directors and the Commissioner. Section 9.4 thus constitutes as absolute anti-takeover restriction for two years, with an additional restriction

for one year on any hostile takeover of Hancock.

The Named Policyholders claimed in their petition to intervene that the PIS and Information Guide are incomplete, misleading, and deceptive because they do not clearly indicate that the anti-takeover provisions effectively give Hancock's directors and officers "virtually unchecked control" over the company during the period of time when they may also be receiving stock options. They reference § 9.2(b) of the Plan which provides that stock options and stock grants may be awarded to directors or executive officers one year after completion of the IPO.

We are not persuaded that the disclosure to policyholders are inadequate, and there is no evidence that these provisions of the Plan will, in any way, prejudice Hancock's policyholders or the insuring public. Mr. Brown testified that Hancock included the anti-takeover provision in the Plan because it will permit Hancock's Board of Directors to focus its attention on implementing its strategy during the transition period, rather than fending off a possible takeover bid during the post-IPO period when the company does not anticipate showing the degree of profitability generally achieved by a traditional stock company. He stated that because Hancock has not had a history as a stock company it would be difficult for the Board of Directors or anyone else to determine appropriate long-term value of the company until it is seasoned to some degree. In addition, Mr. Brown testified that Hancock's preliminary drafts of the Plan contemplated a six-month

restriction on the award of stock options and grants to directors or executive officers. However, upon the recommendation of the Working Group, Hancock revised § 9.2(b) of the Plan to impose the more stringent one-year prohibition on such awards.

Therefore, we find that the Plan's anti-takeover provisions are authorized by § 19E, and Hancock's disclosure thereof, comply with § 19E. We find further that these provisions are not unfair or prejudicial to policyholders or the insuring public.

K. ***Fees***

Section 19(E) provides that "[n]o director, officer, agent or employee of the insurer, or any other person, shall receive any fee, commission or other valuable consideration whatsoever, other than their usual regular salaries and compensation, for in any manner aiding, promoting or assisting in such conversion, except as set forth in the plan approved by the commissioner." Section 9.3 of the Plan expressly incorporates the requirement, and both Mr. Brown and Mr. DeCiccio confirmed that Hancock's directors, officers and employees receive no special compensation for assisting in the demutualization.

L. ***Costs of demutualization***

Section 19E also requires that all reasonable costs related to the review of the Plan "including those costs attributable to the use of staff personnel" by the Commissioner, must

"be borne by the insurer making the filing." Section 9.11 of the Plan provides for reimbursement of the Division's costs, and Mr. DeCiccio testified that, in fact, the Division's costs are being paid or reimbursed by Hancock or JH Financial. Therefore, we find that the Plan conforms to this requirement.[21]

1. Other Issues

1. The Closed Block

Although not required by § 19E, Sections 8.1-8.5 of the Plan provide for the creation of an arrangement known as a Closed Block to protect the reasonable policy dividend expectations of individual policyholders with certain dividend-paying policies or contracts.

Under the Plan, the Closed Block includes most traditional individual or joint participating life insurance policies and individual term life insurance policies that are in force on the effective date of the Plan. Thus, almost all individual policies which currently receive dividends, or are expected to receive dividends and which are in force on the date that the demutualization becomes effective, are included in the Closed Block. In general, premiums paid by Closed Block policies will be credited to the Closed Block, and benefits and policyholder dividends will be paid out of the Closed Block.

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[21] Hancock has paid these fees into an expendable trust under the auspices of the Massachusetts Office of Consumer Affairs and Business Regulation pursuant to G.L. c. 6, § 6A G.L. c. 24-A, §§ I(a) and 2(h).

The funding of the Closed Block is intended to be sufficient to support the Closed Block, including the continuation of dividend scales payable in 1999, if the experience underlying such scales, including the portfolio interest rate, continues. Accordingly, as of January 1, 1999, Hancock's general account assets were allocated to the Closed Block in an amount that produces cash flows which, together with anticipated revenue from the Closed Block business, is expected to be sufficient to support the Closed Block. In the event that the assets in the Closed Block are insufficient to pay the benefits guaranteed under the Closed Block business, the Plan requires Hancock to satisfy these obligations out of the company's general funds.

Because no new policies will be added to the Closed Block, except under certain limited circumstances, over time the number of policies in the Closed Block will decrease and the Closed Block will disappear and its assets will decrease to zero when the last Closed Block policyholder dies or surrenders his or her policy.

Hancock will continue to allocate dividends to Closed Block business as it would have had there been no demutualization. The aggregate amount of dividends paid to Closed Block policyholders will continue to be determined annually by the Hancock Board of Directors. These dividends will be apportioned annually in accordance with applicable law, applicable standards of actuarial practice and with the objectives of: 1) minimizing disproportionate effects on policyholders who remain in the Closed Block as it decreases in size; and 2) exhausting assets allocated to the Closed Block

with the final payment under the last policy contained in the Closed Block.

The Plan provides for ongoing monitoring of the operation of the Closed Block by the Commissioner.[22] Under the Plan, Hancock must: 1) prepare annual financial statements for the Closed Block, and submit to the Commissioner an opinion on these financial statements furnished by its independent public accountants; 2) submit yearly reports by independent public accountants to the Commissioner concerning Hancock's compliance with the Plan's provisions regarding the operation of the Closed Black; and 3) submit periodic reports of the operation of the Closed Block, which must include the opinion of an independent actuary as to whether Hancock, in setting dividend scales for Closed Block business, has acted in accordance with the provision is of Article VIII of the Plan. Following the submission of the third report on the operation of the Closed Block, Hancock must continue to periodically report on the operation of the Closed Block, but its reports need not include such an actuary's opinion if the Commissioner, at Hancock's request, so permits.

In their petitions to intervene, the Named Policyholders and the Davis Trust alleged that the Closed Block, as currently funded, may not

[22] The Plan defines "Commissioner" as "the Commissioner of Insurance of the Commonwealth of Massachusetts or such other governmental officer, body, or authority as becomes the primary regulator of the Company's insurance business under applicable Massachusetts law."

meet policyholders' dividend expectations.[23] In addition, the Davis Trust questioned the assumption that future cash flows will be reinvested at 8.33 percent.[24]

No evidence was produced to support these contentions. Mr. Hunt, the Participants' sole witness on this issue, stated that he is not an expert on Closed Block matters, and his testimony focused on alleged nondisclosures regarding Closed Block funding.

Mr. Perrott's testimony and the Closed Block Memorandum set forth, in significant detail, the assumptions used in developing the Closed

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[23] This allegation was repeated at the hearing by one person who also claimed that there could potentially be a number of deceased policyholders whose families have neglected to file a death claim, thus implying that the Closed Block's mortality assumptions may be too low. We note that the Closed Block includes a provision for such claims incurred before January 1, 1999, but not yet reported.

[24] In its petition to intervene, the Davis Trust also suggested that the Commissioner should continue to monitor the Closed Block throughout the life of the Closed Block, and it questioned the impact of the Closed Block for policyholders who opted out of the class action settlement in Duhaime v. John Hancock Mutual Life Insurance Co., 177 F.R.D. 54 (D. Mass. 1997) ("Duhaime"). In their petition to intervene, the Named Policyholders claimed that policyholders and the insuring public would be affected by the fact that future guarantee fund assessments could be made against the Closed Block. We note that the Plan provides for review of the Closed Block by the Commissioner beyond the first three years. In response to issues regarding Duhaime, Mr. Perrott testified that those claims which predate the Closed Block will not be charged to the Closed Block, and that Hancock has established a procedure under which the Closed Block is not charged for any Duhaime settlements beyond what it would normally pay. Finally, we note that Mr. Perrott testified that although guarantee fund assessments are impossible to predict, such assessments flow through the entire dividend scale and are, in his opinion, fair.

Block funding. Mr. Perrott stated that the methodology used to fund the Closed Block was to assume that the 1999 dividend scales would be paid for all future years and to project forward using the experience underlying that dividend scale. He explained that the fact that the 1999 dividend scale may be lower or higher than scales in prior years is irrelevant so long as the relationship between the scale and the underlying experience remains consistent. At the hearing he further explained that "because one of the experience factors underlying the dividend scale is a portfolio interest rate before expenses of 8.33 percent, that assumption was used for the new money rate because it was the only way that the experience underlying the dividend scale will continue to match that which underlies the '99 dividend scale."[25]

Further, Tillinghast reviewed the funding and assumptions underlying the Closed Block, and concluded that the assets allocated to the Closed Block are reasonably sufficient to enable the Closed Block to meet the goals for which it was created. It also concluded that the classes of policyholders included in the Closed Block are appropriate. We note that the plan that the Commissioner approved in *State Mutual* included a Closed Block.

Based on the foregoing, we find that the composition, funding, and proposed operation of the Closed Block are fair, reasonable, and not

[25] Tr. 4 at 148.

prejudicial to the policyholders or to the insuring public.

- **Hancock's Efforts to Notify Policyholders**

The Named Policyholders assert that the Plan's approval process and vote are flowed because Hancock has been unable to locate many policyholders. The Named Policyholders contend that the absence of notice to these policyholders, and their lack of an opportunity to vote, renders the entire policyholder vote unfair and prejudicial.[26]

In 1998, Hancock began the process of attempting to obtain current addresses for those of its policyholders for whom it knew it did not have a current address. Many of these policies are small industrial policies with face amounts under $1,000, which were often sold door-to-door by agents, who then collected the premiums in person. In 1985, Hancock waived all future premiums for its industrial life insurance business. Therefore, for many years, it has not sent bills to these policyholders or had personal contact with them through its agents.

Mr. DeCiccio testified that Hancock personnel reviewed Hancock's records to create a database of industrial policyholders dating back to the early part of the century. In addition, for monthly debit policies, it mailed address confirmation letters to

[26] The Named Policyholders further contend that because the consideration due to missing policyholders will escheat to the state where the policyholders last resided, which in many cases will be Massachusetts, there is a conflict of interest between the Commonwealth and policyholders. We are not persuaded by this argument.

obtain current addresses. It also engaged the services of an address research vendor to match approximately one million policy records to credit-based databases. Further, on two separate occasions Hancock ran advertisements in 23 different newspapers across the country asking policyholders who had not had contact with Hancock in some time to contact the company. It also posted these advertisements on its website.

As of the date of the mailing of the demutualization packages, Hancock still had no valid addresses for the owners of 400,000 policies. In an effort to reach those policyholders, and with the Commissioner's approval, Hancock mailed a notification letter in lieu of an entire demutualization package, advising recipients of the public hearing and special meeting dates, and informing them how to obtain further information. Hancock found owners of approximately 7,000 more policies through this mailing. Hancock customer service representatives also attended the informational forums in October 1999, and took information for individuals who thought they had an eligible policy but had not received any Plan materials. Hancock is continuing its effort to locate more policyholders.

Preliminary results of Hancock's policyholder vote, as of the date of the public hearing, showed that approximately 94 percent of the votes cast were in favor of the Plan. The percentage of voting by Hancock policyholders exceeds the final voting percentages achieved by Guarantee Mutual, Mutual of New York, and Standard Life in their respective demutualizations. Mr. DeCiccio testified that based on the results as of the date of the hearing, even assuming that all of Hancock's missing policyholders were to vote against

the Plan, the Company still would have more than the necessary two-thirds vote in favor of the Plan for implementation under Section 19E. Final results after the November 30, 1999 special meeting of policyholders show that 93.72 percent of the 3,425,977 votes cast by approximately 1.1 million policyholders were in favor of the Plan.

While we stress the importance of Hancock's continuing efforts to locate policyholders, we find that based on its reporting of votes, the lack of votes from missing policyholders likely would not have had any effect on the final results of the overall policyholder vote on the Plan. Therefore, we find that the absence of votes from the still-missing policyholders does not render the notice and policyholder vote unreasonable or so prejudicial to policyholders or the insuring public as to compel disapproval of the Plan.

- **Adequacy of Plan Disclosures**

The Named Policyholders assert that descriptions in the PIS and Information Guide of policyholders' interests in Hancock are misleading. In addition, in their petition to intervene, they contended that Hancock has not clearly explained that policyholders voting against the Plan still are entitled to receive consideration if the reorganization is approved.[27] As a result, they contend that the Plan is unfair and prejudicial to policyholders.

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[27] In addition, the Named Policyholders contend that the Plan does not make adequate disclosures about the anti-takeover and the default to cash provisions. These issues have been discussed above.

We are not persuaded by these contentions. We note preliminarily, that § 19E requires the Commissioner to ensure that the Plan is not prejudicial to policyholders and the insuring public. It does not specify the scope of the notice or information that an insurer seeking to demutualize must provide to its policyholders. Nor does it require the Plan, which, by its very nature, is complicated document, to be fully comprehensible by each and every policyholder.

a. *The Description of Policyholder Interests*

The Named Policyholders claim that the descriptions in the PIS and Information Guide of policyholders' interests in Hancock are misleading because they do not state that: 1) Hancock is run for the exclusive benefit of policyholders; 2) policyholders are the owners of Hancock; and 3) policyholders have numerous rights and privileges exceeding the right to vote and share in the surplus from a liquidation. These participants further allege that the Plan is misleading and prejudicial because it fails to inform policyholders that they are giving up "equity" or "proprietary" ownership rights in Hancock and that these rights will be extinguished by the Plan.[28]

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[28] The Named Policyholders reference internal Hancock memoranda and tax opinions from Hancock's counsel that refer to policyholder rights as "interests" in the nature of corporate equity interests." These references were provided in the context of a tax opinion under § 7701 of the Internal Revenue code. That section defines "stock" as

(Continued on following page)

Section 19E(3) refers to policyholders' interests in a mutual insurer as "membership interests." The Plan, Information Guide, and PIS similarly adopt the term "membership interests" to describe policyholders' rights. The PIS and Information Guide each summarize the basic Plan provisions. Each of these documents further refers policyholders to the Plan as the source for more specific details.

Article I of the Plan defines "membership interests" as follows:

"Membership Interest" means, as of the Effective Date, all the rights or interests in respect of each insurance policy and annuity contract of the Company including, but not limited to, any right to vote and any rights which may exist with regard to the surplus of the Company not apportioned or declared prior to the effective Date by the Board for policyholder dividends, including any such rights in liquidation or reorganization of the Company, but shall not include any other benefits, values, guarantees, dividend rights or other rights expressly conferred by an insurance policy or annuity contract.

We find no merit in the Named Policyholders' claim that Hancock's characterization

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including shares in an insurance company and "shareholder" as including an insurance company member. That Congress deemed interests in stock and mutual companies analogous for purposes of taxation under the Internal Revenue Code does not mean they are indistinguishable for all other purposes.

of policyholders' rights is misleading, Hancock's definition of membership rights is consistent with § 19E and with Massachusetts law, which recognizes a distinction between a mutual policyholder's right to share in the annual divisible surplus of the insurer and a shareholder's equity interest in a corporation. *See, Harhen v. Brown,* 46 Mass. App. Ct. 793, 808 n.14 (1999) ("Although policyholders, unlike stockholders in a corporation, do not have an ownership interest that can be transferred to others, they nevertheless have a financial interest in the mutual insurance company."). *See also, Peters v. Equitable Life Assurance Soc'y.*, 200 Mass. 574, 584, (1909) (the relation between an insurance company and a participating policyholder with respect to dividends is not in the nature of a fiduciary relationship but that of a debtor and creditor).

We find that the Plan is not misleading or prejudicial to policyholders or the insuring public in its description of policyholders' interests in Hancock.

b. *The Right to Receive Compensation Regardless of Individual Vote*

The Named Policyholders also contended in their petition to intervene that the Plan is misleading, deceptive and unfair to policyholders because it does not make clear that policyholders voting against the Plan still are entitled to receive consideration in the event the reorganization is approved. We find no merit in this contention.

The Information Guide sent to all policyholders states that "[i]f our conversion Plan is approved, eligible policyholders will receive compensation in the form of cash, stock or policy credits, without having to surrender any insurance policy or annuity contract benefits, guarantees, values or dividend rights." The Information Guide further states, "You are not required to attend or participate in the Informational Forums, the Public Hearing or the Special Policyholder Meeting in order to continue your policy or to receive your compensation under the Plan." The Information Guide also informs policyholders that;

A "yes" vote means that you approve John Hancock's proposed conversion to a stock company. If the conversion Plan is approved and becomes effective eligible policyholders will receive compensation in the form of stock, cash or policy credits.

A "no" vote means that you disapprove of the conversion Plan, and would like John Hancock to remain a mutual insurance company.

Further, it states that the Cash/Stock Compensation Card "should be completed if you would prefer stock over cash regardless of how you vote on the ballot because the proposed demutualization may be approved by the policyholders."

These selected descriptions of the significance of a vote make it reasonably clear to policyholders that all policyholders will receive compensation in the event the Plan

is approved, regardless of their individual votes for or against the Plan. Therefore, we find that the Plan's descriptions of policyholder eligibility for compensation upon approval of the Plan are not unfair, prejudicial, misleading or deceptive.

c. *The Role of Morgan Stanley Dean Witter*

The Named Policyholders also contend that the information sent to policyholders failed to disclose: 1) that Morgan Stanley is the lead underwriter for the IPO; and 2) the estimated fees Morgan Stanley will earn as a result of the IPO. In addition, they contend that Morgan Stanley's role in the IPO implies that its fairness opinion is biased.[29] We are not persuaded by these arguments. First, Hancock appointed Morgan Stanley as lead manager in September 1999, after Morgan Stanley had delivered its fairness opinion. Therefore, Hancock could not have disclosed this fact in the information sent to policyholders. Mr. Schiff acknowledged that

[29] In support of this contention they rely upon Butler v. Provident Mutual Life Ins. Co., Ct of Common Pleas of Philadelphia County, Civ. No. 9901-0180 (Sept. 17, 1999). That reliance is misplaced. The court in that case conditioned the effectuation of a plan of demutualization on the circulation of a revised policyholder information statement which, among other things, disclosed the financial advisor's compensation and contingency fee arrangements. However, the court based its decision on the fact that the company had not disclosed that its advisors had concluded that a full demutualization was better for policyholders than the partial conversion contemplated by that plan.

the existing fee arrangements were disclosed in the Policyholder Information Statement.

In addition, Mr. Kirkland testified that it is customary for an insurance company's financial advisor in the demutualization also to serve as lead manager for the IPO. In every major Untied States life insurer demutualization since 1986, including the State Mutual demutualization in Massachusetts, the financial advisor that delivered the fairness opinion also was appointed the lead underwriter in the IPO. Moreover, Morgan Stanley's review in connection with rendering its fairness opinion has been supplemented by the independent review conducted by Wasserstein on behalf of the Division. No credible evidence has been presented to show either that Morgan Stanley's or Wasserstein's fairness opinions should be questioned.

- **Additional Issues Raised by Participants.**

During the course of the proceeding, the Participants have raised a number of other issues relating to Hancock's Board of Directors and senior management. In addition, they have made several assertions regarding the accuracy of certain statements and and alleged inconsistencies between the information sent to policyholders and information from other sources. Although the Participants have not pursued these issues, Hancock has offered credible evidence to refute these concerns and to demonstrate that these issues should not preclude us from finding that the Plan is not prejudicial to policyholders.

We note that Hancock has stated that for four years following demutualization, it will: 1) remain domiciled in Massachusetts and thereafter will seek to redomesticate only with the permission of the Commission; 2) keep its home office and primary executive offices located in Boston and will change location only with permission of the Commissioner; 3) maintain Massachusetts as the location where the majority of its employees are based; and 4) maintain its total level of community activity and charitable giving in Massachusetts at no less than its aggregate level during the past three years.

IV. Conclusion

For the reasons stated above, we find and conclude that the Plan of Reorganization, adopted on August 31, 1999 by the Board of Directors of John Hancock Mutual Life Insurance Company complies with the requirements of Section 19E of chapter 175 of the Massachusetts General Laws, and is not prejudicial to its policyholders or the insuring public. Therefore, we hereby approved the Plan of Reorganization.

SO ORDERED.

/s/
Sharon S. Kamowitz, Esq.
Presiding Officer

/s/
Richard A Cody, Esq.
Presiding Officer

Dated: December 9, 1999

AFFIRMED.

/s/
Linda Ruthardt
Commissioner of Insurance

Dated: December 9, 1999

This decision may be appealed to Superior Court pursuant to G.L. c. 30A, § 14.

APPENDIX F

[LOGO]
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COMMISSIONER OF INSURANCE

Docket No. F-99-04

Proposed Plan of Reorganization of John Hancock Mutual Life Insurance Company

MEMORANDUM AND ORDER ON PETITIONS TO INTERVENE

I. INTRODUCTION

A mutual life insurance company may seek to convert from a mutual company to a stock company pursuant to G.L. c. 175, § 19E ("Section 19E"). Under this statute, both the Commissioner of Insurance ("Commissioner") and the policyholders must approve a company's plan of demutualization before it may take effect. The Commissioner must hold a hearing on a plan, at which the insurer, its directors, officers, employees, and policyholders have the

right to appear and be heard; the policyholders exercise their right to approve or disapprove a plan by voting on it.

On August 31, 1999, John Hancock Mutual Life Insurance Company ("Hancock") filed a Plan of Reorganization ("Plan") seeking to convert from a mutual life insurance company to a stock life insurance company. In order to conduct a complete and fair review of Hancock's plan, the Commissioner, on September 1, 1999, issued a Notice of Public Hearing ("the notice of hearing") pursuant to the Administrative Procedures Act, G.L. c. 30A ("c. 30A") and the Formal Rules of the Standard Rules of Practice and Procedure, 801 C.M.R. 1.01, *et seq.*, subject to such modifications as are permitted by law. The hearing on the Plan is scheduled for November 17, 1999.

The notice of hearing offered an opportunity for any person to file a written statement concerning the Plan, or to submit a notice of intent to make an oral statement at the hearing. In addition, it stated that any person who desired to intervene or participate in the hearing, other than by making a written or oral statement, was required to submit, by October 4, 1999, a written request specifying whether he or she sought to intervene or participate, the specific procedural rights desired, and the basis for the petition. It also specified that a petition must include a copy of all proposed discovery requests, and a statement explaining why such discovery is sought.

On October 4, 1999, Mutual of America Life Insurance Company ("MOA") filed a *Verified Conditional Petition to Intervene*. On that same date, three Hancock policyholders, Loretta M. Harhen, the John S. Katzman Family Trust, and Aaron E. Landy, Jr. (collectively, the "Named Policyholders") and The Center for Insurance Research,

Inc. ("CIR") jointly filed a *Petition for Leave to Intervene*.[1] The Brett M. Davis Trust ("Davis Trust") filed a *Petition and Intervention and Request to File Petition Out of Time* on October 8, and it filed an amended petition on October 13. Each petition also requested discovery.

By letter dated October 8, 1999 ("October 8 Order"), we notified Hancock and the petitioners that we would hear argument on the petitions on October 14, 1999.[2] In preparation for this hearing, we ordered the petitioners to file statements that addressed: 1) the basis, with citation to relevant case law, for their contentions that they are likely to be specifically and substantially affected by this proceeding; 2) the names of any witnesses whose testimony the petitioners would seek to present at the November 17, 1999, hearing, a description of their qualifications, and a short summary of their expected testimony; and 3) any procedural rights, other than those listed in 801 CMR 1.01(9)(e), that they would seek as participants in this

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[1] The Named Policyholders and CIR assert that they, and all Hancock policyholders, were prejudiced by the deadline imposed for filing intervention petitions and discovery requests. This argument is moot. These petitioners did in fact timely file their intervention motion and discovery requests. As for other Hancock policyholders, these petitioners may not assert claims of prejudice concerning policyholders they do not represent. *See*, *Robinson v. Dep't. of Public Utilities*, 416 Mass. 668, 671 (1993).

[2] The Davis Trust's petition was received after we had notified Hancock and the other petitioners of the October 14 hearing. We sent a second letter to the Davis Trust inviting it to participate at that hearing and present argument in support of its request to file later and in support of its petition to intervene. We also ordered Hancock to respond to this petition by October 13.

proceeding, in the event that a petition to intervene is denied.

On October 12, 1999, Hancock field memoranda opposing the intervention petitions of MOA, the named Policyholders and CIR. Hancock filed its opposition to the Davis Trust's petition on October 13, 1999. In addition, Hancock filed responses to the petitioners' discovery requests, and identified certain publicly available documents that Hancock contends are responsive to the petitioners' request. In response to MOA's petition, Hancock also filed a request that the Commissioner order MOA to submit its dispute to binding arbitration.

Also on October 13, 1999, the Named Policyholders, CIR, and the Davis Trust filed motions to continue the October 14 hearing and to have it consolidated with a prehearing conference scheduled for October 19. In addition, the Davis Trust and MOA filed statements in compliance with the October 8 Order. That same day, we denied the motions to continue the October 14 hearing.[3]

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[3] These petitioners alleged that they were provided with inadequate notice of the October 14, 1999, hearing because they were not given three days notice as required by 801 CMR 1.01(7)(a)(2). However, the notice provided was sufficient. 801 CMR 1.01(4)(d) provides:

> . . . computation of any time period referred to in 801 CMR 1.01 shall begin with the first day following the act which initiates the running of the time period. The last day of the time period is included unless it is a Saturday, Sunday, or legal holiday or any other day on which the office of the Agency is closed, when the period shall run until the end of the next following business day. When the time period is less than seven days, intervening days when the Agency is closed shall be excluded.

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All petitioners were represented by counsel at the October 14, 1999 hearing. The Named Policyholders and CIR submitted a motion for reconsideration of the order denying their motion to continue and consolidate. In addition, they submitted statements in response to the October 8 Order. We denied their motion for reconsideration, but we accepted the statements. The Petitioners and Hancock extensively argued their positions and responded to our questions. Because Hancock indicated that it waived its objection to the late filing of the Davis Trust's petition, we did not address the timeliness of that petition.

We orally issued our rulings on the petitions to intervene at an October 19, 1999, prehearing conference. This memorandum sets forth the basis for our rulings.

II. SUMMARY OF ARGUMENTS

A. Mutual of America Life Insurance Company

MOA argues that it is entitled to intervene in this proceeding in order to assert its rights as a group annuity policyholder eligible to participate in Hancock's demutualization. MOA argues that, as a group annuity policyholder, it has a right, pursuant to Section 19E(1), to appear and be heard at the hearing. MOA contends that

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We notified the petitioners of the October 14 hearing, by letter dated and sent by facsimile, on Friday, October 8. Because the Division was closed the following Monday for Columbus Day, the notice period began on Tuesday, October 12. Including the date of the hearing, the three day notice requirement was met.

the right to appear and be heard gives it the right to intervene as a party.

It argues, in the alternative, that it is likely to be substantially and specifically affected by the proceeding. First, it claims that as a participating group annuity contract holder, it has contributed to Hancock's surplus for over fifty years, and that it has a right to receive its fair share in the demutualization. Second, it claims that in certain correspondence between MOA and Hancock, Hancock acknowledged that the proposed demutualization would affect MOA. Finally, it claims that the demutualization would impair MOA's right to receive dividends because it is not included in the closed block.[4]

It claims that its interest is substantial because, as a result of Hancock's recent determination that MOA is ineligible to participate in the Plan, MOA expects to lose "tens of millions of dollars" that it claims it should receive as a policyholder under the Plan. MOA asserts that it will be specifically affected because, it claims Hancock has no other similar contracts, and its contradict is the only one

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[4] The closed block is a mechanism established under the Plan by which Hancock proposes to allocate certain income producing assets for the benefit of holders of individual or joint traditional life insurance policies that are currently paying or are expected to pay policy dividends, as well as for term life insurance policies in force as of the effective date of the reorganization. The purpose of the closed block is to protect the policy dividend expectations of these policies after the proposed demutualization. Hancock expects that assets allocated to the closed block will produce cash flows which, together with anticipated revenues from the policies included in the closed block, will be reasonably sufficient to provide for payment of policy benefits, taxes, and direct asset acquisition and disposition costs, and for continuation of policy dividends.

excluded from participating in the demutualization. MOA emphasizes that certain documents, which have been made publicly available, show that Hancock had initially intended that all policyholders, including MOA, would be eligible to participate in the Plan. MOA contends that the issues it seeks to raise in the proceeding will aid the Commissioner in determining the fairness of the Plan.

B. The Center for Insurance Research, Inc.

CIR asserts that it should be permitted to intervene because, as a non-profit corporation devoted to insurance issues, it represents the Named Policyholders, other unnamed Hancock policyholders and "members of the public who are interested in the integrity of the regulatory process and fair outcome in this matter." CIR also argues that its intervention is appropriate because its counsel has prior experience before the Division of Insurance ("Division"). CIR contends that the Plan may result in decreased competition in the insurance industry and an increase in the cost of insurance policies to its members and the insuring public. Finally, CIR suggests that it is entitled to intervene because Hancock's parent company, following approval of the Plan, will be domiciled in Delaware, and has committed to maintaining a Massachusetts-domiciled subsidiary for only four years. Therefore, it argues, there is a risk of significant job loss and loss of charitable activity by Hancock in Massachusetts in the near future.

C. The Named Policyholders

The Named Policyholders own Hancock policies that range in face value from two thousand dollars to fifteen million dollars. They base their arguments in support of

intervention on claims that the Plan or elements thereof are prejudicial to policyholders. They assert that they are substantially and specifically affected by these proceedings because they are long-term policyholders who hold equity interests in Hancock that will be affected by the finality of a determination that the Plan is fair. They argue that: 1) the conversion will extinguish their governance and voting rights; 2) intervening in this proceeding is the only way in which they and other policyholders will have a meaningful opportunity to fully inform themselves or influence other policyholders' votes on the Plan; 3) their equity interests in Hancock are a constitutionally protected property interest and, therefore, they have a constitutional right to intervene and to examine the fairness of the Plan's stock allocation formula; 4) their future policy benefits may be substantially and significantly affected by the funding of the closed block; 5) their policies represent a substantial source of financial security to them; and 6) they are entitled to inquire into the reasons Hancock determined not to grant policyholders preemptive rights under the Plan.

D. The Brett M. Davis Trust

The Brett M. Davis Trust is a Hancock policyholder that owns a modified whole life policy valued at ten million dollars. It alleges that it is substantially and specifically affected by the Plan because the Plan is unfair and prejudicial to large policyholders. It contends that voting rights under the Plan are prejudicial because the Plan contains a cap on the number of votes per policy. As a result, it states that the number of votes it is accorded is not in proportion to its financial interest in Hancock. The

Davis Trust also challenges the Plan's method of apportioning stock. In addition, it argues that the absence of preemptive rights in the Plan affects it and other large policyholders proportionally more than it affects small policyholders. Finally, the Davis Trust argues that, because it opted-out of the class action settlement in *Duhaime v. John Hancock Mutual Life Insurance Co.*, 177 F.R.D. 54 (D. Mass. 1997), it should have the opportunity to discover how Hancock will fund settlements to it and other such plaintiffs, and whether any such payments will affect the assets and assumptions underlying the closed block.

E. HANCOCK

Hancock opposes the petitions to intervene for several reasons. First, it disputes the contentions of MOA and the Named Policyholders that policyholders' right, under Section 19E(1), to appear and be heard is equivalent to a grant of full party status. It argues that this right resembles the rights of a participant under 801 CMR 1.01(9)(e), and that the Legislature did not intend to allow policyholders full party status. In addition, Hancock contends that we should exercise our discretion to disallow the petitions because intervention would cause undue delay and expense and would unnecessarily prolong the hearing without any corresponding benefit.

Hancock argues that its contract with MOA is a reinsurance agreement, and that MOA it [sic] is not a holder of a group annuity policy entitling it to participate in the demutualization. It contends that MOA does not challenge the terms of the Plan but, instead, challenges only the application of the Plan. Therefore, it argues, MOA cannot

show that it is substantially and specifically affected by this proceeding. Hancock also argues that MOA is no different than others that Hancock has determined to be ineligible to participate in the Plan. Hancock states that these include parties to other reinsurance agreements and owners of policies that have been terminated or are not in force, nonparticipating, and/or non-voting. Finally, Hancock argues that there is no need for MOA's intervention because the Plan provides a mechanism for resolving disputes regarding voting rights and the right to receive consideration. Hancock proposes that the Commissioner order that the dispute between it and MOA be resolved by binding arbitration, as provided for in the Plan.

Hancock argues that CIR cannot show that it has a specific or direct interest in the proceeding. It disputes CIR's contentions that its claimed expertise in insurance and its representation of the Named Policyholders and other unnamed policyholders are sufficient grounds for intervention.

Hancock contends that neither the Named Policyholders nor the Davis Trust are specifically affected because the issues raised by them are of general application to all policyholders, and because they have not shown specific interest or peculiar damage which sets them apart from other Hancock policyholders. In addition, Hancock contends that these petitioners have not shown that they are substantially affected by the Plan. It contends that the concept of "substantial" is a proportional concept, in relation to the entire issue of demutualization. Therefore, it argues, the value of a particular policy cannot be determinative in deciding whether the substantial and specific standard is met. Hancock also argues that intervention by these petitioners is unnecessary because they can raise

concerns about the Plan by appearing at the hearing. It notes that Section 19E charges the Division with representing the rights of all policyholders, and it states that the Division has hired independent actuarial and financial experts who are expected to offer opinions about the Plan. Hancock also points out that policyholders' objections can be addressed by exercising their right to vote on the Plan.

III. ANALYSIS

A. INTRODUCTION

In reviewing the petitions to intervene, we consider Section 19E, G.L. c. 30A, § 10, and 801 CMR 1.01(9). Section 19E(1) specifies that the insurer filing a plan of demutualization, and its directors, officers, employees and policyholders are entitled "to appear and be heard" at the hearing on the plan.

G.L. c. 30, § 10(4) and 801 CMR 1.01(9) provide broad agency discretion in reviewing petitions to intervene. Chapter 30A, § 10 provides, in pertinent part, that "[u]nless otherwise provided by any law," an agency

> (4) may allow any person showing that he may be substantially and specifically affected by the proceeding to intervene as a party in the whole or in any portion of the proceeding, and allow any other interested person to participate by presentation of argument orally or in writing, or for any other limited purpose, as the agency may order.

801 CMR 1.01(9)(a) allows any person who may be substantially and specifically affected by a proceeding to file a petition to intervene or participate. 801 CMR 1.01(9)(c) provides that the presiding officer may, in his or her

discretion, allow a petition to intervene. 801 CMR 1.01(9)(d) and (e) set forth the rights of intervenors and participants. Both of these subsections specify that the presiding officer "may permit" the intervention or participation. Therefore, even if we conclude that a petitioner is likely to be substantially and specifically affected by the proceeding, we need not grant intervenor status. *See also, Boston Edison v. Dep't of Public Utilities*, 375 Mass. 1, 45 (1978) (decision to grant intervention, and the extent of any rights to be accorded therewith, lies within the broad discretion of the agency); *City of Newton v. Dep't of Public Utilities*, 339 Mass. 535, 543 n.6 (1959) (discretion to limit intervention is intended to permit agencies to control the extent of participation by persons not sufficiently and specifically interested to warrant full participation, which might interfere with the adjudicatory process). Further, 801 CMR 1.01(9)(e) permits a presiding officer to grant participation rights, in the form of submission of an *amicus* brief and the right to argue orally, if a petitioner may be affected by a proceeding but is not likely to be substantially and specifically affected.

MOA and the Named Policyholders allege that the language in Section 19E which states that policyholders are entitled "to appear and be heard" entitles them to participate as parties in this proceeding. Regardless of whether Mutual of America is, in fact, a policyholder of Hancock, we are not persuaded that the right to appear and be heard confers full party rights. A party to a proceeding may offer testimony, conduct discovery, and cross-examine witnesses. Such expansive rights are not contemplated by the plain language of the statute which provides only for the right to appear at the hearing on the Plan and the right to offer written and oral comments.

Nonetheless, we are not persuaded by Hancock's arguments that the right to appear and be heard is necessarily a limitation on policyholders' right to participate in the proceeding. Nor are we persuaded that we should exercise our discretion to disallow the petitions solely on the ground that allowing intervention could delay the hearing and could result in additional expense. Section 19E requires that the Commissioner conduct a hearing in order to determine that the plan: 1) is not prejudicial to the policyholders or the insuring public; 2) grants fair and reasonable consideration to policyholders; and that 3) the insurer's management has not "sought to reduce, limit, or affect the number or identity of the insurer's policyholders to be entitled to participate . . . or to otherwise secure for . . . management any unfair advantage." To aid in the review of the Plan, the Division has engaged the services of various experts who are expected to offer their reports. In addition, the Commissioner welcomes the input of policyholders with respect to the issues before her. Section 19E requires Hancock to bear the full cost of its demutualization, and the burden is on Hancock to demonstrate that the Plan is not prejudicial to policyholders or the insuring public.

Thus, we consider whether the petitioners may be substantially and specifically affected by the proceeding as provided in G.L. c. 30, § 10(4) and 801 CMR 1.01(9). The Supreme Judicial Court has suggested that substantiality is a proportional concept that requires a showing that the petitioner is affected to a greater degree, financially or

otherwise, than the group of affected persons at large. *Robinson v. Dep't of Public Utilities*, 416 Mass. 668.[5]

In order to be specifically affected, a person must demonstrate "peculiar damage to himself" *i.e.*, damages distinct from those that may be suffered by the entire class of affected persons. *Attorney General v. Dep't of Public Utilities*, 390 Mass. 208, 217 (1983) (residential customer of electric company denied intervention in utility rate proceedings where he failed to demonstrate any peculiar harm to himself); *See, Boston Edison*, 375 Mass. at 46 (extensive participation should be permitted only where special circumstances so justify). *See also, Mass. Federation of Teachers v. School Committee of Chelsea*, 409 Mass. 203, 208-09 (1991) (finding no abuse of discretion under Mass. R. Civ. P. 24 where court denied parents intervention in suit concerning state takeover of school, in part, because parents identified no characteristic that distinguished them from all other parents represented by school committee).

We shall use these criteria to evaluate the arguments advanced by the petitioners.

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[5] In *Robinson*, the Department of Public Utilities ("DPU") allowed petitioners who either represented large groups of affected persons, had a major financial stake in the regulated entity, or relied on the regulated entity's services to provide other service to the public, to intervene in utility rate proceedings. At the same time it denied intervention to an individual residential rate payer. The Court found no abuse of discretion in excluding private individuals representing only themselves even though others were permitted to intervene. The court held that an agency is entitled to balance a petitioner's individual interest with the need to conduct proceedings in a complete, efficient and orderly fashion.

B. Mutual of America Life Insurance Company

Although, in its oral presentation, MOA attempted to frame its petition as a challenge to the fairness of the Plan, its petition and arguments focus on challenging Hancock's determination that MOA is not eligible to participate in the demutualization. MOA argues that it has a right to receive its share in the demutualization, that the dispute arose when Hancock recently determined that MOA was ineligible to participate in the Plan, and that its future dividends are not protected because it is not included in the closed block. Further, MOA's discovery request is principally aimed at obtaining information concerning Hancock's determination that MOA is not eligible to participate in the demutualization. Similarly, MOA proposes to submit the testimony of four witnesses to establish MOA's eligibility under the Plan and the effect of Hancock's denial of eligibility.

The purpose of the hearing is to allow the Commissioner to review the Plan to ensure that it is not prejudicial to policyholders or the insuring public. Section 19E does not provide for determinations by the Commissioner regarding individual eligibility to participate in a plan of demutualization. Unlike the other petitioners, MOA does not contest any portion of the Plan. Rather, the sole basis for its contention that it is likely to be substantially and specifically affected by the proceeding is its claim that its ineligibility to participate in the Plan will result in its failure to receive a distribution under the Plan. This issue is beyond the scope of this proceeding and, therefore, we are not persuaded that MOA is substantially and specifically affected by the proceeding.

Whether MOA is an eligible policyholder ultimately depends upon the nature of, and its rights and obligations under, its contract with Hancock. MOA acknowledges that their relationship may ultimately require separate resolution, and it concedes that the Commissioner may not have authority to resolve a contractual dispute. Thus, allowing MOA to intervene would serve no final purpose.[6]

We note that Section 19E(9) requires the Commissioner, in reviewing the Plan, to "find that the insurer's management has not . . . through any other means sought to . . . affect the number or identity of the insurer's policyholders to be entitled to participate in such plan." Hancock, however, does not dispute that MOA would be entitled to participate in the demutualization if it is determined to be an eligible policyholder. Rather, Hancock disputes only the forum for the resolution of this issue. Therefore, we conclude that MOA's petition does not raise any claims under this subsection.

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[6] In *Cablevision Systems Corp. v. Dep't. of Telecom. and Energy*, 428 Mass. 436 (1998), the Supreme Judicial Court held that the Department of Telecommunications & Energy properly denied Cablevision the right to intervene in the restructuring proceeding of Boston Edison Company to assert alleged competitive harm which could result from approval of the restructuring. Cablevision's complaint concerned its personal relationship with a cable television affiliate of Boston Edison, not the electric utility itself, and did not impact upon the fairness of the restructuring to the public. The Court held that the department's "statutory obligation to consider the public interest did not require it to consider the consequences of competition between Cablevision and Edison's unregulated affiliate." *See also*, *Rothberg v. Schmiedeskamp*, 334 Mass. 172, 177 (1956) ("The injection of an independent controversy by intervention is improper.") (citations omitted).

Accordingly, we deny MOA's petition to intervene in this proceeding. We also, therefore, deny its request for discovery. However, like any other person, it will be permitted to offer public comment at the November 17, 1999, hearing.

Further, we also deny, as premature, Hancock's request that we order MOA to resolve its dispute with Hancock through binding arbitration as provided by the Plan. The Commissioner has not yet completed her review of the Plan, has not approved it, and therefore, its provisions are not in effect. Hancock has identified no authority under which we may compel MOA to submit its contractual rights to binding arbitration at this time.

C. The Center for Insurance Research, Inc.

Because CIR is not likely to be substantially and specifically affected by this proceeding, we shall not allow it to intervene or participate. First, CIR is a non-profit organization whose membership is comprised of contributors and people who have asked to be put on CIR's mailing list. It is not a Hancock policyholder and it has not shown that the Plan may cause substantial and specific harm to CIR itself. CIR was unable to explain why its interests could not be met by taking advantage of the invitation, extended in the notice of hearing, for any person to speak at the November 17, 1999, hearing.

To the extent that CIR claims to represent the Named Policyholders, its petition is superfluous because those policyholders have sought to intervene individually. Further, although CIR claims to represent other Hancock policyholders in addition to the Named Policyholders, it does not provide any information about them. Nor was it

able, at the October 14 hearing to explain the basis for its claim that it could know opinions regarding the Plan of policyholders in general.

Similarly, we will not permit CIR to intervene on behalf of the insuring public. CIR's claims that it focuses its activities in the area of insurance, and that the Plan could impact product availability, policyholder treatment, and corporate giving in Massachusetts are insufficient bases upon which to permit CIR to intervene. *See, Harvard Square Defense Fund v. Planning Bd. of Cambridge*, 27 Mass. App. Ct. 491, 495 (1989) (mere statement of corporate purpose expressing general civic interest is insufficient to confer standing where organization failed to establish harm to a corporate legal right). *See also, Save The Bay, Inc. v. Dep't of Public Utilities*, 366 Mass. 667, 672 (1975) (increased participation by persons whose rights are at best obscure will, in the absence of exact adherence to requirements as to standing, seriously erode the efficacy of the administrative process").

We note that our decision is consistent with the conclusion reached in the *Memorandum of Decision and Procedural Order* on the *Plan of Reorganization of State Mutual Life Insurance Company of America*, DOI Docket No. F95-1 ("*State Mutual*"). The arguments CIR advanced for intervention in that proceeding were substantially the same as those it asserts here.

Because we deny CIR's petition to intervene, we also deny its request for discovery.

D. The Named Policyholders

The generalized claims asserted by the Named Policyholders are not sufficient to warrant intervention because they have not shown that they will be substantially and specifically affected by the proceeding. The Named Policyholders fail to show how they are affected more substantially than all other Hancock policyholders whose equity rights will be affected by the Plan. Moreover, the Commissioner is statutorily authorized and required to protect the interests of policyholders at large, and the Named Policyholders do not allege specific harm or prejudice. In addition, the Named Policyholders have not persuaded us that intervention would, in any way, further communication between policyholders.

Furthermore, even if the Named Policyholders' equity interests in Hancock are considered constitutionally protected property interests, they still are not entitled to intervene as of right. First, the Division is not adjudicating policyholders' rights with respect to those interests but rather Hancock's statutory right to demutualize under Section 19E. The Plan's provision for the conversion of policyholders' current equity interests to a different form of equity, *i.e.*, stock (or cash if the policyholder so chooses), does not convert the Commissioner's findings on the fairness of the Plan to an adjudication of policyholders' property interests. The policyholders have a role in determining whether the conversion will occur because two-thirds of all voting policyholders must approve the Plan in order for demutualization to occur.

Second, the existence of a property interest invoking constitutional due process considerations does not require that the Named Policyholders be accorded full party status

in this proceeding. *See, Tedford v. Massachusetts Housing Finance Agency*, 390 Mass. 688, 698-99 (1984). In determining what process is due, the Division is entitled to balance the Named Policyholders' interests with the need to conduct this proceeding in a fair, efficient, and expeditious fashion. *Id.*, *Robinson*, 416 Mass. at 670. *See also, Tedford*, 390 Mass. at 699 (due process rights of tenants of apartment complex financed and subject to regulation by state agency not entitled to adjudicatory hearing on rent increases because due process "is satisfied, perhaps more than satisfied," by providing tenants access to underlying data supporting proposal and an opportunity to respond).

Although we conclude that the Named Policyholders have failed to show that they may be substantially and specifically affected by this proceeding or that they have a constitutional right to intervene, we find that they may be affected by this proceeding. Therefore, in the interest of having a full and fair hearing, each of the Named Policyholders will be permitted to participate by making a statement of reasonable length at the November 17, 1999, hearing and by submitting a brief. In our discretion, and consistent with *State Mutual*, we will also permit the Named Policyholders to offer relevant testimony of their previously identified witnesses. If the Named Policyholders seek to exercise these privileges, they must pre-file all direct testimony and accompanying exhibits no later than November 8, 1999. We will also permit them to submit, for our consideration, questions which, in our discretion, we may pose to Hancock's witnesses. Those questions shall be limited to the issues set forth in their petition to intervene. If the Named Policyholders seek to exercise this privilege, they must file all questions no later than November 10,

1999. These participation rights do not include a right to cross-examine witnesses.

Neither the Named Policyholders' right to appear and be heard, nor the grant of permission to participate encompasses the right to engage in discovery. Therefore, we deny their request for discovery. Nonetheless, we note that a significant number of documents are available for their review.

E. THE BRETT M. DAVIS TRUST

Like the Named Policyholders, the Davis Trust has not shown that it is likely to be substantially and specifically affected by the proceeding. Although it articulated ways in which it may be affected by the allocation of stock under the Plan, it fails to show how any such effect is different from that expected by the other Hancock policyholders who own policies valued at one million dollars or more. The same holds true for its claims with respect to the prejudicial effect of voting rights under the Plan, and in regard to those policyholders who opted out of the class action settlement in *Duhaime v. John Hancock Mutual Life Insurance Co.* Therefore, the Davis Trust's claims lack the specificity necessary for intervention.

Although we deny the Davis Trust's petition to intervene, we find that it may be affected by the proceeding. Therefore, in the interest of having a full and fair hearing, we shall in our discretion, permit the Davis Trust to participate to the same extent as the Named Policyholders. We deny the Davis Trust's request for discovery for the same reasons that we denied the discovery request of the Named Policyholders.

So ordered.

October 27, 1999

/s/ Sharon S. Kamowitz
Sharon S. Kamowitz, Esquire
Presiding Officer

/s/ Richard A. Cody
Richard A. Cody, Esquire
Presiding Officer

APPENDIX G

MA ST 175 § 19E

§ 19E. Conversion from mutual to stock company

Upon compliance with the requirements and completion of the proceedings prescribed by this section, a domestic mutual life insurance company may (i) convert into a domestic stock life insurance company or (ii) so convert as part of a plan of reorganization in which a majority or all of the common shares of the domestic stock life insurance company is acquired by a parent corporation or another corporation which may be, but need not be, a corporation organized for such purposes and may be a subsidiary or other affiliate of such domestic mutual life insurance company prior to such acquisition, and, in either case, may merge as part of the plan of demutualization with a domestic stock life insurance company or a corporation organized under chapter one hundred and fifty-six B and the consideration to be provided in such merger may be shares of the resulting or surviving corporation or any other corporation, cash, or other consideration. Any such merger shall be authorized under this section and approved as provided under paragraph (2) and not pursuant to section nineteen A.

Such conversion shall be accomplished pursuant to a plan which complies with the following:

(1) Such plan shall be filed with the commissioner and shall be approved by him as conforming to the requirements of this section and as not prejudicial to the policyholders of such company or to the insuring public, after a hearing thereon for which notice was given to the insurer, its directors, officers, employees and policyholders,

all of whom shall have the right to appear and be heard at the hearing.

(2) Such plan shall be approved by vote of not less than two-thirds of the votes of the insurer's policyholders voting thereon in person, by proxy or by mail at a meeting of policyholders called for that purpose pursuant to such reasonable notice and procedure as may be approved by the commissioner. Upon such approval, the conversion shall be effective as of the date specified in the plan. On and after such date, all the rights, franchises and interests of the insurer in and to every species of property shall be vested in the converted insurer without any deed or transfer and the converted insurer shall succeed to all the obligations and liabilities of the insurer.

(3) In exchange for all membership interests in the company, such plan shall give each eligible policyholder appropriate consideration. Said consideration shall be determinable under a fair and reasonable formula approved by the commissioner, and shall be based upon the insurer's entire surplus as shown by the insurer's financial statement most recently filed with the commissioner pursuant to section twenty-five, including all voluntary reserves but excluding contingently repayable funds and outstanding guaranty capital shares at the redemption value thereof, and without taking into account the value of nonadmitted assets or insurance business in force.

(4) Such plan shall give each eligible policyholder a preemptive right to acquire his proportionate part of all of the proposed capital stock of the insurer or of the proposed parent corporation or other corporation within a designated reasonable period, and to apply upon the purchase thereof the amount of his consideration, as determined

under paragraph (3), except that the plan may provide that a policyholder may not purchase or receive stock pursuant to this section if it has an aggregate subscription price of two thousand dollars or less and that such preemptive right will not apply to policyholders who reside in jurisdictions in which the issuance of stock is impossible, would involve unreasonable delay or would require the insurer to incur unreasonable costs; provided, however, that any such policyholder shall receive his consideration in cash; and, provided further, in the instance of a plan of reorganization in which the appropriate consideration received by eligible policyholders under paragraph (3) is stock of a corporation in a transaction authorized under this section, or other consideration as approved by the commissioner or, without limiting the generality of the foregoing, as permitted under this paragraph (4) the plan shall provide either (i) that no policyholder shall have any preemptive right to acquire any of the proposed capital stock of the insurer or of the proposed parent or other corporation or (ii) for preemptive rights on such other terms as approved by the commissioner. Notwithstanding the above, the commissioner retains the full authority to disapprove such plan in accordance with the provisions of paragraph (1).

(5) The policyholder eligible to participate in the distribution of consideration and to purchase stock shall be the person whose name appears on the conversion date on the insurer's records as owner of a policy under which there is a right to vote and which, on both the December thirty-first immediately preceding the conversion date and the date the insurer's board of directors first votes to convert to stock form, is in full force for its full basic benefits with no unpaid premium or consideration at the

expiration of any applicable grace period, or which is being continued under a nonforfeiture benefit and continues to be eligible for participation in the insurer's annual distribution of divisible surplus.

(6) Shares are to be offered to policyholders at a price not greater than to be thereafter offered under the plan to others.

(7) Such plan shall provide for payment to each policyholder of consideration which may consist of cash, securities, a certificate of contribution, additional life insurance or annuity benefits, increased dividends or other consideration or any combination of such forms of consideration.

(8) Such plan, when completed, shall provide for the converted insurer's paid- in capital stock to be in an amount not less than the minimum paid-in capital stock and the net cash surplus required of a new domestic stock insurer upon initial authorization to transact like kinds of insurance.

(9) The commissioner shall find that the insurer's management has not, through reduction in volume of new business written, or cancellation or through any other means sought to reduce, limit or affect the number or identity of the insurer's policyholders to be entitled to participate in such plan or to otherwise secure for the individuals comprising management any unfair advantage through such plan.

Nothing in this section shall be deemed to prohibit the inclusion in the conversion plan of provisions under which the individuals comprising the insurer's management and employee group shall be entitled to purchase for cash at

the same price as offered to the insurer's policyholders, shares of stock not taken by policyholders on the preemptive offering to policyholders, in accordance with such reasonable classification of such individuals as may be included in the plan and approved by the commissioner.

The conversion plan may also include provisions restricting the ability of any person or persons acting in concert from directly or indirectly offering to acquire or acquiring the beneficial ownership of ten percent or more of any class of common stock of the converted insurer or the parent corporation or other corporation.

No director, officer, agent or employee of the insurer, or any other person, shall receive any fee, commission or other valuable consideration whatsoever, other than their usual regular salaries and compensation, for in any manner aiding, promoting or assisting in such conversion, except as set forth in the plan approved by the commissioner. This provision shall not be deemed to prohibit the payment of reasonable fees and compensation to attorneys at law, accountants and actuaries for services performed in the independent practice of their professions, even though also directors of the insurer.

For the purposes of determining whether a conversion plan meets the requirements of this section and any other relevant provisions of this chapter, the commissioner may employ staff personnel and outside consultants. All reasonable costs related to the review of a plan of conversion, including those costs attributable to the use of staff personnel, shall be borne by the insurer making the filing.

APPENDIX H

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss

SUPERIOR COURT
DEPARTMENT OF THE
TRIAL COURT

CIVIL ACTION NO.: 00-00087

THOMAS TIERNEY and DORIS G. MARAH, individually and on behalf of other similarly situated policyholders of John Hancock Mutual Life Insurance Company,

Plaintiffs,

v.

John Hancock Mutual Life Insurance Company, John Hancock Financial Services, Inc., John Hancock Life Insurance Company

And

the following Directors of John Hancock Mutual Life Insurance Company, Stephen L. Brown, Chairman of the Board, Chief Executive Officer and Director; Foster L. Aborn, Vice Chairman of the Board, Chief Investment Officer and Director; David F. D'Alessandro, President, Chief Operations Officer and Director; Samuel W. Bodman, III; Joan T. Bok; I. MacAllister Booth; Wayne A. Budd; John M. Connors, Jr.; Robert E. Fast; Edward H. Linde;

Dr. Kathleen Foley Feldstein; Nelson S. Gifford; Michael C. Hawley; E. James Morton; Richard F. Syron; Robert J. Tarr, Jr.; and former Directors, Lawrence K. Fish; William L. Boyan; John F. Magee; and Chester V. Vappi;
And
Honorable Linda Ruthardt, Commissioner of Insurance, Commonwealth of Massachusetts,
Defendants.

FIRST AMENDED VERIFIED CLASS ACTION COMPLAINT AND REQUEST FOR JUDICIAL REVIEW

FIRST AMENDED VERIFIED CLASS ACTION COMPLAINT AND REQUEST FOR JUDICIAL REVIEW

NATURE OF THE CASE

1. This class action is brought on behalf of the policyholders of John Hancock Mutual Life Insurance Company, directly against John Hancock Mutual Life Insurance Company, John Hancock Financial Services, Inc., John Hancock Life Insurance Company and their Directors, seeking a declaration pursuant to G.L. c. 231A, § 1 *et. seq.* that the implementation of a "Plan of Reorganization of John Hancock Mutual Life Insurance Company" (the "Plan") constitutes unfair and deceptive conduct, breaches of contract, breaches of fiduciary duties and a violation of the Massachusetts Conversion Statute, M. G.L. c. 175 § 19E(3). Plaintiffs and the Class also seek damages for their claims including the creation of a

constructive trust. Finally, the Representative Plaintiffs and the Class, acting pursuant to G.L. c. 30A § 14, appeal from a final determination of the Commissioner of Insurance approving the Plan.

JURISDICTION AND VENUE

2. This court has jurisdiction over this matter pursuant to G.L. c. 212, § 4. c. 214, § 1 and c. 231A. Venue is appropriate in this County as Defendants' principal place of business is located in Suffolk County, and venue in Suffolk County is appropriate against the Commissioner of Insurance pursuant to G.L. c 30A. § 14(1)(b). Plaintiffs believe that this Court properly has jurisdiction to decide the contractual and/or statutory issues raised by this Amended Complaint pursuant to G.L. c. 212. § 4. c. 214 § 1 and c. 231A § 1 *et seq.*

PARTIES

3. Representative Plaintiff, Thomas Tierney, is a current policyholder of a life insurance policy issued by John Hancock Mutual Life Insurance Company and has been for fifty-six years, since 1943. Mr. Tierney was a member of John Hancock Mutual Life Insurance Company. Mr. Tierney is a resident of Massachusetts, residing at 7 Lomas Drive, Framingham, MA 01701-3950.

4. Representative Plaintiff, Doris G. Marah, is a current policyholder of a life insurance policy purchased from John Hancock Mutual Life Insurance Company and has been for forty years, since August 3, 1959. Ms. Marah is a resident of Missouri with an address at HCR3, Box 3683, Theodosia, MO 65761. Ms. Marah was a member of

John Hancock Mutual Life Insurance Company. References herein to Mr. Tierney, Ms. Marah and other members of the former mutual company are as "Members."

5. Defendant, John Hancock Mutual Life Insurance Company ("JHM"), was a mutual insurance company incorporated and chartered under the laws of Massachusetts with its principal place of business at John Hancock Place, Boston, Massachusetts 02116.

6. Defendant, John Hancock Financial Services, Inc. ("JHFS"), is a stock company organized pursuant to Delaware law. Under the Plan described below, JHFS has become the parent corporation of John Hancock Life Insurance Company, with a principal place of business at John Hancock Place, Boston, Massachusetts 02116.

7. Defendant, John Hancock Life Insurance Company (JHLIC), is an insurance company owned and operated by JHFS with a principal place of business at John Hancock Place, Boston, Massachusetts 02116. JHLIC came into existence pursuant to the terms of the Plan.

8. Defendant Management includes the Board of Directors of JHM, who are individually named Defendants and who formulated and implemented the Plan. Management includes the following individual Directors of JHM: Stephen L. Brown, Chairman of the Board and Chief Executive Officer; Foster L. Aborn, Vice Chairman of the Board and Chief Investment Officer; David F. D'Alessandro, President, Chief Operations Officer and Director; Samuel W. Bodman, III; Joan T. Bok; I. MacAllister Booth; Wayne A. Budd; John M. Connors, Jr.; Robert E. Fast, Esquire; Dr. Kathleen Foley Feldstein; Nelson S. Gifford; Michael C. Hawley; E. James Morton; Richard F. and

Robert J. Tarr. Jr.; and former Directors, William L. Boyan, Lawrence K. Fish; John F. Magee and Chester V. Vappi.

9. Defendant, the Honorable Linda Ruthardt, is the Commissioner of the Massachusetts Department of Insurance (the "Commissioner"). On December 9, 1999, the Commissioner issued a Decision approving the Plan, following a hearing.

SUMMARY OF THE ACTION

10. Members of JHM had contractual rights under the legislative charter granted to JHM in 1862 and under their existing contracts of insurance with JHM that precluded the implementation of the "Plan" proposed by JHM. The "Plan" changed the fundamental operating purpose of JHM from a "mutual company" to a "stock company." The Plan was proposed and approved pursuant to purported authority under the Massachusetts Conversion Law, c. 175, § 19E.

11. Implementation of the Plan constituted breach of Members' contractual rights created by the JHM charter and their contracts of life insurance and has thereby caused the loss of property rights without consent and substantial economic damages to Members. The conduct of the Management of JHM in proposing and seeking to implement the Plan is contrary to the Charter and their fiduciary duty to JHM and Members and was designed to benefit Management to the economic detriment of Members. For these reasons this class action challenges the Commissioner's approval of the Plan and requests the Court to declare the Plan contrary to Members' contracts and the law and to award Members their substantial monetary losses caused by implementation of the Plan.

Members Of John Hancock Owned Valuable Property Interests Pursuant To The JHM Charter And By-Laws Of John Hancock And The Members' Insurance Contracts

12. JHM was created in 1862 and has been operated through the last 138 years as a mutual insurance company pursuant to a charter granted by the Commonwealth of Massachusetts. A mutual company is a cooperative enterprise wherein the members (policyholders) are both the insurers and the insureds, and the company is owned by its policyholders for whose mutual benefit insurance is provided at cost. Before the Plan was implemented, JHM was a mutual insurance company owned by its policyholders.

13. On April 21, 1862, JHM was issued a charter by the Commonwealth of Massachusetts authorizing its incorporation "for the purpose of making insurance upon lives; with all the powers and privileges; and subject to the duties, liabilities and restrictions set forth in so much of the fifty-eighth chapter of the General Statutes as relates to mutual insurance companies, and all other acts which are or may be in force relative to such companies." A copy of this Charter is attached as Exhibit A.

14. Pursuant to JHM's 1862 Charter, a member of JHM obtained a membership interest in JHM by purchasing a policy from JHM. A JHM membership provided ownership rights in JHM.

15. Insurance companies, such as JHM, provide life insurance coverage by ensuring that the insurer's assets are adequate to pay insurance claims when they are filed. To meet its economic obligations, a mutual insurer charges premiums such that the expected value of premium

payments is in excess of the corresponding value of anticipated benefits and expenses. When assets in JHM were more than sufficient, as determined by the JHM Board portions of policyholders' premiums were returned to the policyholders in the form of dividends. The mutual form of corporate ownership allows policyholders to obtain insurance protection at cost.

16. As a mutual insurer, JHM offered dividend paying insurance contracts known as "participating policies." These policies differ from "non-participating policies" in that an insurer selling "non-participating policies," determines the price of its product based upon the insurer's best estimate with regard to mortality, interest, expense and other factors. A contingency factor and profit loading are then added to the preliminary price to determine a final price which remains constant. If the insurer's estimates are too low, it will lose money, and if they are high enough, it will make money. In the latter case, it may be unable to sell policies because competitors can offer a similar product for a better price. The relationship between the insurer and the policyholder with a non-participating policy is an arms-length debtor-creditor one.

17. By contrast, "participating policies" such as those offered by JHM had their prices determined using formulae that are structurally similar to those used in the "non-participating" process except that there is no added "profit loading" and the primary assumption factors will have a very conservative rather than a "best-estimate" expression. This results in up-front product prices which are usually higher than those of similar "non-participating" vehicles. As experience unfolds, however, the "participating policies" will have the respective portions of their up-front prices, that turn out, in retrospect, to have been

excessive, returned to them as dividends, a process that, over the long run, results in adjusted contract prices that are equal to the respective costs that the insurer actually incurs in providing the insurance coverage. The insurer's relationship to its policyholders, because of the former's duty to scrupulously provide the latter with an "at cost" price, will be similar to that of a trustee to a beneficiary.

18. Every Member of JHM had an ownership interest in JHM and was entitled to a share in the value of JHM in proportion to the sums they paid on account of their policy after expenses and benefits were paid.

19. JHM historically paid dividends to its members. JHM distributed dividends on a proportionate basis according to a retrospective or historic formula to its members. Each member thus received a share of JHM's surplus, proportionate to the extent of their JHM ownership interest.

20. The Members of JHM hold beneficial title to the property of JHM. So long as JHM was an operating mutual, Members could not recover on their ownership interest in JHM since under the JHM Charter it was dedicated to operation of the chartered purpose of JHM. If JHM determined to cease operating as a mutual pursuant to its charter, JHM's fair value had to be divided amongst its members on a proportionate basis based upon their membership interests. Upon dissolution, the distribution of this fair value should have been made to the Members. Upon dissolution, Members' beneficial rights should have reverted to the Members of JHM.

21. To further the singular objective of JHM's charter, which is to "make insurance on lives," as a mutual

insurer, JHM was operated under a set of by-laws. The by-laws did *not* authorize JHM to do anything other than operate as a mutual insurer "to make insurance on lives." The By-Laws provided that JHM's business and affairs were to be controlled and managed by its Board of Directors ("Board"). The Members of JHM elected the Board and membership in JHM was a prerequisite to becoming a Director. Each Director was nominated for election either by the Members or by the Members of the Board. The Board determined the distribution of surplus funds to the Members and reported on the JHM assets and liabilities at a required annual meeting.

22. Since JHM was a mutual, Defendant Management was required to operate JHM in the interest of the Members solely to further JHM's singular mutual insurance purposes as set forth in its charter. Management of JHM were required to act as a trustee operating JHM solely for and on behalf of its Member policyholders.

23. The fiduciary duties of JHM Management to JHM, in the event of dissolution or a sale of assets, was owed solely to its policyholder members. JHM Management was not authorized to act in the interest of non-policyholders, including investors with interests different from or adverse to Members. Likewise, JHM Management was not authorized to act in their own self-interest to the detriment of policyholders.

The Massachusetts Conversion Statute

24. In 1991, the Massachusetts Legislature enacted a statute that authorized the conversion of domestic mutual life insurance companies to stock life insurance

companies. MA. St. 175 § 19E *et seq.* ("the Conversion Statute or Conversion Law").

25. The Conversion Statute contains provisions that are permitted as part of a Plan or are required to be fulfilled before a mutual insurer is purportedly authorized to convert to a stock company including, *inter alia,* that:

a. A [Conversion] Plan has to be filed with the insurance commissioner and approved by the Commissioner but only if it conforms to the requirements of the Conversion Statute and is not prejudicial to the policyholders or insuring public;

b. The Plan also is required to be approved by vote of not less than two-thirds of the insurer's policyholders who voted;

c. The Plan is also required to provide eligible policyholders "appropriate consideration" determined under a fair and reasonable formula approved by the commissioner and which was "based upon the insurer's entire surplus as shown by the insurers financial statement most recently filed with the commissioner pursuant to section twenty-five, including all voluntary reserves but excluding contingent[ly] repayable funds and outstanding guaranty capital shares at the redemption value thereof, and without taking into account the value of nonadmitted assets or insurance business in force."

d. The Plan may include provisions restricting the ability of any person or persons acting in concert from directly or indirectly offering to acquire or acquiring beneficial ownership of 10% or more of any class of common stock of the converted stock company; and

e. No director, officer, agent or employee can receive, except if approved by the commissioner, any fee commission or other valuable consideration (other than usual regular salaries and compensations) for aiding, promoting or assisting in any approved conversion.

Management's Plan To Sell John Hancock Mutual

26. On May 11, 1998, the Board authorized JHM management to prepare a plan to demutualize pursuant to the purported authority conferred under the Conversion Statute. On August 31, 1999, the Board adopted its so-called "Plan of Reorganization of John Hancock Mutual Life Insurance Company." A copy of the Plan is attached as Exhibit B. Although called a "reorganization," the Plan is effectively a sale of the equity interests or Memberships to a publicly traded stock holding company to be called John Hancock Financial Services, Inc. ("JHFS"). In effect, the Plan proposed to negate or alter JHM's operating purpose by a sale of JHM.

27. The Plan provided that each Member was to be allocated consideration consisting of a number of shares in JHFS or their equivalent. The number of shares allocated was based on both a fixed component and a variable component. The fixed component allocated 17 shares for each policy owned by a Member on the Plan's effective date. Art. 7.1 of the Plan Exhibit B (hereinafter references to sections in the Plan are designated simply as "Art."). The variable component allocated a number of shares based upon a formula purportedly intended to reflect each participating policy's contributions to the JHM's surplus historically and prospectively. The allocation formula, called "Historical Plus," was based upon an actuarial

theory which allocated more shares to policyholders that had recently acquired policies.

28. The "Historical Plus" formula applied by JHM allocates consideration based, in part, on projected future surplus contributions as opposed to an allocation based exclusively on historical surplus. The "Historical Plus" method deviated from JHM's own longstanding policy and practice of distributing surplus to members based upon an historical formula. The Historical Plus method is contrary to Massachusetts law in force when JHM was chartered in 1862 and current law. JHM failed and refused to disclose the allocation formula to its Members when it solicited their votes in favor of the Plan and failed and refused to disclose its formula to Members during the hearing on the Plan.

29. The JHM Plan provided that the value of policyholders' ownership "shares" will be determined on the date of an Initial Public Offering ("IPO") of stock in the newly created JHFS. Art. 5.2 Exhibit B. JHM under the Plan first transferred all of its assets and liabilities to JHFS which then sold stock to the public for cash. Art. 5 Exhibit B. JHFS then used this cash to purchase the memberships of certain policyholders in JHFS. Art. 7 Exhibit B. JHM thereafter ceased to exist since it was fully absorbed by JHFS. JHFS thereafter became a corporate parent and became the 100% owner of the stock of the wholly owned company formed from JHM's transferred residue, but was created and called "John Hancock Life Insurance Company."

30. The Plan provided that the value to be paid to JHM policyholders by JHFS for their membership interests would be based upon the IPO share price as follows:

a. For policyholders that elected to be paid in or receive by operation of the Plan cash or policy credits, payment in an amount equal to the higher of (a) the IPO share price; or (b) the average closing share price for the first twenty days of trading, up to 120% of the IPO share price; and

b. For policyholders that elected payment in stock, the value of their shares was determined by the market.

31. The Plan provided that the source of money for payment to policyholders electing to be paid in cash or policy credits was generally the amount of the proceeds obtained from the IPO net of certain offering expenses and other transaction expenses. If this amount was insufficient to pay policyholders electing cash or policy credits, the remaining allocable shares would be distributed in the form of common stock in the newly created JHFS. Art. 7(d) Exhibit B.

Management's Plan To Create A Closed Block

32. Upon the effective date of the Plan, JHM became "John Hancock Life Insurance Company" (JHLIC). The new JHLIC is fully owned and operated by JHFS.

33. After the sale, JHM policies remained in force. The Plan proposed to create a so-called "Closed Block" which is a process that contains segregated assets to be allocated to JHLIC to pay claims and provide dividend payments on existing individual whole life and term policies of the dissolved JHM. Art. 8 Exhibit B. The Plan represented that assets would be allocated to the Closed Block in an amount that would produce cash flows which,

together with anticipated revenue to be generated from the Closed Block assets and policies was anticipated to be sufficient for payment of claims and taxes and to provide for the continuation of the 1999 dividend scales if the experience underlying those scales continues. Future benefits of affected policies would be secured and paid by operation of this so-called "Closed Block."

34. The purpose of a "Closed Block" in connection with a mutual to stock company conversion is to protect the contractual rights of policyholders to a "participating policy" by segregating assets to secure the pre-existing "participating policies". The policies thus continue to "participate" with respect to the "Closed Block" assets in that the cash flows and anticipated revenues from the assets support the payment of claims and expenses associated with the "Closed Block." Unlike the typical "Closed Block," JHM Members "participating policies" are no longer participating because the "Closed Block" operated by JHFS through JHLIC (the "JHLIC Closed Block") operates substantially different than a participating "Closed Block."

35. The "JHLIC Closed Block" materially affected Members' existing charter, contractual and ownership rights in that:

a. Members are no longer owners of the assets which secured their JHM participating policies;

b. Members no longer have rights to be paid from a surplus in which they have an ownership interest, but only have a contractual right to receive dividends from segregated assets, in the "Closed Block," that they no longer own;

c. Members no longer have the right to control, through election of a Board, those persons who would control the business affairs of the Closed Block; and

d. Members' JHM policies no longer fully "participate" in the assets segregated in the "Closed Block."

36. The Plan effectively replaced a Member's contractual "participating policy" with an interest in the "JHLIC Closed Block" to be operated by JHFS. The Plan proposed to operate the "JHLIC Closed Block" fundamentally different than a mutual manages policyholders' interests. Policyholders are no longer owners of a mutual insurer, but became mere creditors of JHFS secured by "JHLIC Closed Block" assets.

37. A typical "Closed Block" generally is based upon three (3) primary factors. These factors relate to anticipated future expenses, investment income and mortality costs. The application of these factors is intended to be sufficient to provide that funds will be available even if actual experience is worse than anticipated. If actual experience is in fact better than the anticipated, higher than anticipated dividends would then be returned to policyholders.

38. The "JHLIC Closed Block" proposed in the Plan deprived Members of the security provided by their participating policies because the policyholders' security and contractual interests underlying the "Closed Block" are quite different than the policyholders' security and interest would be in their own mutual insurer or in a typical fully participating "Closed Block". Under the Plan, administrative expenses were not provided for. This means that the participating policies will become nonparticipating with respect to expenses and the policyholders will not be

able to benefit from cost cutting or expense reductions which would increase dividends. Billions of dollars less in assets were not segregated in the "Closed Block" because the JHM Plan excluded payment of expenses from the "Closed Block."

39. The "JHLIC Closed Block" also significantly changed investment returns for "participating policies." The Plan provided that JHFS will pay for any shortfalls by the "Closed Block" for guaranteed rates. Simultaneously herein, JHFS owes duties to JHFS shareholders to minimize losses. JHFS management is therefore internally "conflicted." Investment return assumptions underlying participating policies are generally based upon investment decisions that would normally provide greater returns than will likely be generated under the "JHLIC Closed Block" process.

40. The "JHLIC Closed Block" also includes large numbers of missing policyholders who may now be or soon will be deceased. The mortality assumptions underlying the "JHLIC Closed Block" have not accounted for these potential policyholder claims.

41. The "JHLIC Closed Block" policies therefore operate significantly different than JHM "participating policies." The "JHLIC Closed Block" as a result constitutes a material revision and deprivation of Members' rights under the JHM charter and their contractual rights. Members contractual rights have been damaged by reason of the "JHLIC Closed Block" because their JHM policies are no longer participating and are backed by billions of dollars less in assets than required for them to be participating and to protect Members interest.

42. Under the Plan, existing Management operate both the to-be-created JHFS and JHLIC. Under the "JHLIC Closed Block," Members "participating policies" are no longer being operated pursuant to a set of by-laws and a board of directors consisting of JHM Members. Rather, decisions with respect to the "JHLIC Closed Block" and are now made by JHFS, whose directors will be required to act in the interest of its stockholders, not in the interest of policyholders affected by the "JHLIC Closed Block."

Management's Plan To Maintain Control Of The Stock Company

43. Although the Plan proposed an Initial Public Offering ("IPO"), the Plan contained "anti-takeover" provisions designed to foreclose control of the enterprise by outside investors for a period of at least three years after the IPO. The Plan provided that no person or group may directly or indirectly offer to acquire or acquire a beneficial interest of 10% or more of the JHFS Common Stock until two years after the effective date of the Plan. Art. 9.4 Exhibit B. Then, for another year thereafter, the Plan provides that no person or group may directly or indirectly offer to acquire or acquire a beneficial interest of 10% or more of JHM Common Stock without prior permission of both the Board and the Commissioner of Insurance. The Conversion Statute purports to authorize such "anti-takeover" provisions. G.L. c. 175, § 19E, ¶ 9.

44. After the first year of this initial three year "window period" created by the Plan's "antitakeover" provisions, the Plan then permits the award of stock options and/or stock grants to any Executive Officer or

Director. Art. 9.2(b) Exhibit B. Management, Directors, Executive Officers and Officers are then allowed to purchase JHFS Common Stock in the open market subject to time limitations restricting their purchase during the initial 20 day period of the IPO.

Implementation Of The Plan Deprived Members Of Their Property Interests Contrary To The Charter, By-Laws And Participating Policies And, Therefore, Could Not Be Legally Authorized By The Conversion Law

45. On August 31, 1999, the Board of JHM adopted the Plan and filed it with the Commissioner of Insurance. On September 1, 1999, the Commissioner of Insurance issued a Notice of Public Hearing and scheduled a hearing on the Plan for November 17, 1999.

46. The Commissioner, thereafter, approved the Plan on December 9, 1999. A copy of the Commissioner's Decision is attached as Exhibit C.

47. Implementation of Management's Plan deprived Members of their property interests in JHM and illegally transferred their property rights to JHFS in violation of JHM's charter, By-Laws and their ownership rights.

48. JHM's Charter did not authorize implementation of the Plan. The JHM Charter provided that the sole purpose of JHM was to provide life insurance coverage as a mutual insurer. The terms of JHM's Charter, which incorporate Massachusetts law, provides that the fair value of JHM should be distributed to Members upon the surrender of the charter, sale of the JHM assets or dissolution of the insurer. The Plan did not allow JHM to liquidate its assets, but instead, provided that those assets

would be transferred to JHFS. Under JHM's charter, Members owned an equitable interest in the going concern value of JHM. Under the JHM Charter, Members agreed that if JHM went out of business, the total going concern value of JHM would be proportionately distributed to them.

49. Management however ended JHM's purpose as a mutual insurer. Having made a decision to terminate JHM, Management had a duty to individual JHM Members to distribute the full going concern value of JHM to JHM Members. The Plan violated the JHM charter in that:

a. The Plan failed to distribute 100% of JHM's going concern value to JHM Members by limiting this value to the IPO price, by incorporating anti-takeover provisions in the Plan which did not exclusively benefit Members and that prevented the value of JHM to be distributed to Members from being determined in an open market in which JHFS stock was unrestricted;

b. The Plan utilized an "Historical Plus" formula for allocating proportionate shares to Members which was not authorized by the Charter and the law in that the formula was based upon estimated future contributions rather than on an "historical" method; and

c. The Plan created a "Closed Block" which materially modified a Members' charter and contractual interests obtained upon purchase of a JHM policy.

50. The Plan provided that Members could sell their ownership and control of JHM. Under the Plan, Members were denied their right to maximize the value of this sale by allowing their mutual insurer to be sold on the open

market to the highest bidder. To maximize value, the aggregate value of the insurer should be determined using the auction (free market) process. The Plan, however, provided for Members to relinquish their legal right of control over JHM, yet the Plan deprived Members' rights to receive the "control premium" they would otherwise be paid if JHM were sold in the free market by way of an auction.

51. Management of JHM also breached their fiduciary duty to maximize the value paid to Members for the sale of their ownership and control of JHM when it elected to employ and adopt as part of the Plan "anti-takeover" provisions and/or by not using the antitakeover provisions to auction the value of JHM created by the Members exclusively for the benefit of Members. A purpose of "antitakeover provisions" such as those adopted by the Plan, is to keep a company's stock widely held for a period of time to allow the company adequate time to conduct a full and fair auction for the benefit of prior mutual owners and to provide for adequate time to convert from a mutual to stock operation without having to deal with hostile or other takeover attempts. Here, the Plan failed to utilize the proposed antitakeover provisions to auction JHM's value exclusively on behalf of the true owners of JHM assets, the Members, but rather on behalf of other recent outside investors. The Plan's anti-takeover provisions precluded Members from selling their insurer in a free market auction, and otherwise diluted their ownership rights and caused them substantial damage.

Management Was Conflicted And Failed To Act In The Interest Of JHM Members

52. Management's Plan was designed to "buy out" Members' control of JHM at a discount of fair market or going concern value and to transfer this control to JHFS Management for at least three years, who could then sell the control to the highest bidder thereafter at a fair market value. Management's Plan was not devised to maximize the benefit to Members, but was devised to benefit Management or outside investors to the detriment of JHM Members.

53. Management's decision to eliminate JHM triggered a duty to obtain the maximum value at a sale exclusively for the Members' benefit. Contrary to this duty, Management's Plan incorporated provisions not designed to maximize the value to be realized be policyholders from the sale of their Memberships. In this connection under the Plan:

a. The value of the consideration paid to policyholders who elected cash or policy credits was limited to the average IPO Stock Price paid within the first 20 days of trading up to 120% of the IPO price instead of the Fair Market Value or going concern value as determined by open bidding by outside investors;

b. The Plan failed to provide for an open market or open bidding process to determine the value of policyholders' ownership interests. Instead, the Plan incorporated anti-takeover provisions that limited or prevented any investor from obtaining a controlling interest. Such provisions deterred investors seeking to pay a control premium which would have maximized value for policyholders' ownership interests;

c. The Plan permitted Management to utilize anti-takeover provisions to benefit other investors, which provisions were clearly not for the benefit of Members;

d. The Plan allowed existing Management and all other shareholders to obtain control at a discount below fair value; and

e. The Plan created a "Closed Block" that negated policyholders' existing contractual interests and which was based upon assumptions different than those that had supported Members' participating policies and was underfunded.

54. The Plan did not provide a fair process for the distribution of the full value of JHM to Members. The use of anti-takeover provisions in connection with a mutual to stock conversion is intended to be used to maximize value for the policyholders of the converted mutual. A mutual to stock conversion requires a reasonable period of time for the insurer to adjust to its new stock operation and for the market to determine the insurer's value. Anti-takeover provisions are intended to delay full open market bidding or a hostile takeover of an insurer by prohibiting control premium offers for a period of time. The Plan implemented an unfair process to determine the value of JHM by limiting the valuation to the trading value of JHFS stock in the first 20 days of trading. This process was unfair and improper since the true trading value or fair market value of JHM could not be determined until the expiration of the anti-takeover provisions. The restriction of stock by anti-takeover provisions caused the stock to be traded at substantial discounts to fair market or going concern value because, *inter alia,* these provisions precluded willing purchasers to offer JHM Members a control premium.

55. The Plan entitled Management to obtain stock options after the first year of the three year period between the IPO date and the expiration of the antitakeover provisions. Management thus is enabled to purchase stock options when the price is artificially depressed by the antitakeover provisions and exercise them once the stock is traded on a fully open market.

56. Management was further conflicted by reason of their agreement with Morgan, Stanley Dean Witter ("Morgan Stanley") to act as the underwriter for the IPO. JHM engaged the firm of Morgan Stanley to provide services in connection with the formation and implementation of the Plan and to provide an opinion of the fairness of the Plan to eligible policyholders with respect to the exchange of Memberships for cash, policy credits or stock, but limited to assumptions provided by the Board. Morgan Stanley, based on the assumptions limited by the conflicted Board, provided its opinion to the Board that the Plan was fair to eligible policyholders.

57. The Board and Morgan Stanley also agreed that Morgan Stanley would act as the underwriter or managing underwriter for the IPO under which the value of the consideration for Memberships would be determined. This provided Morgan Stanley a substantial economic incentive to find the proposed Plan fair so it could proceed as the underwriter. To date, the Board has failed to disclose its agreement with Morgan Stanley to act as the underwriter for the IPO. It is known, however, that the Board-Morgan agreement allowed Morgan Stanley (and its investors) to obtain the right or option to purchase shares of common stock for its own account. Morgan Stanley therefore acquired yet an additional interest that the IPO offering share price be low or at a discount of fair market value so

that it too could benefit by subsequent increases in the JHFS stock price. By reason of Morgan Stanley's own conflict, the Board has failed to inform itself, with an independent advisor, of the actual going concern value of the Membership interests.

58. JHM's agreement with Morgan Stanley and the Plan's antitakeover provisions precluded Members from obtaining maximum value for their memberships. As the lead underwriter, Morgan Stanley, *de facto* determined the IPO price. At the same time, Morgan Stanley had an option or right to purchase JHFS shares for its own account.

59. In addition, the IPO price did not reflect the maximum value of the Members' ownership rights because the IPO price included a "spread" which constituted the value to be paid to Morgan Stanley for its underwriting services.

Management Failed to Inform Itself and/or Members of Material Information

60. It is standard practice in connection with an initial public offering or with a mutual company conversion for the underwriter or other qualified person or persons to perform an appraisal of the company for the purpose of determining its fair market value, going concern value or other similar value. The Board and/or Morgan Stanley thus knew or should have informed themselves of the fair market value or going concern value of JHM.

61. In soliciting Members vote on the Plan, Management issued a Policyholder Information Statement, Parts 1 and 2 ("PIS"). Exhibits D-1 and D-2. The PIS stated that the proportionate value of JHM to be provided to each JHM member receiving cash or policy credits could be valued at a maximum of 20% over the IPO stock price in the first 20 days of trading, but not less than the IPO stock price. PIS. Part 1. p.6. Exhibit D-1. The PIS failed to provide any disclosure that this value equates or may be a discount from the fair market value or going concern value of JHM. PIS, Part 2, p. A.10-A.16. Morgan Stanley also provided an opinion to Management as to the fairness, from a financial point of view, of the exchange of policyholder memberships for JHFS common stock, cash or policy credits. This fairness opinion, provided to Members as part of the PIS, failed to disclose the appraised going concern value or fair market value of JHM. Information about the going concern value or fair market value as it related to the anticipated IPO price in the first 20 days of trading was material to the determination as to how to vote on the Plan, whether to elect cash or common stock, and whether the Plan from a financial point of view was fair to Members.

62. The Plan provided that eligible policyholders who were eligible for, but did not expressly elect, common stock would be presumed to prefer cash. Without adequate disclosures about the actual appraised going concern value of JHM or that the IPO price of JHM in the first 20 days of trading will be or may be less than going concern value, Management's conduct in presuming a preference for cash, not stock, was unfair, deceptive and contrary to fiduciary duties owed to Members.

Representatives Thomas Tierney and Doris Marah Were Long-Time Owners Of John Hancock Mutual Life Insurance Policies

63. Over fifty-six (56) years ago, on September 8, 1943. Plaintiff Thomas Tierney became a JHM member under a JHM Juvenile Monthly Premium Life Policy. This insurance contract is a participating policy which provided Mr. Tierney the right to participate in any "Annual Surplus Distribution." A copy of Mr. Tierney's policy is attached as Exhibit E.

64. Over 40 years ago, on August 3, 1959, Plaintiff Doris Marah became a JHM Member under a JHM Personal Security Endowment Policy. This insurance contract is a "participating policy" which provides Ms. Marah the right to participate in any "annual divisible surplus." A copy of Ms. Marah's policy is attached as Exhibit F.

65. Mr. Tierney was a member of JHM and his policy explicitly provided: "The Assured is hereby notified that by virtue of this policy he is a member of the John Hancock Mutual Life Insurance Company." Ms. Marah was likewise a Member of the John Hancock Mutual Life Insurance Company.

66. Mr. Tierney's and Ms. Marah's policies are currently in force and have been in force since 1943 and 1959, respectively. Implementation of the Plan will negate their contractual and/or membership rights and deprive them of their property interests in JHM.

67. Mr. Tierney timely objected to John Hancock's proposal at the time the proposal was submitted to the Commissioner for public review. He provided written objections and appeared and testified at a hearing intended to

hear such objections. Ms. Marah also objected to the Plan through her attorney, Paul Benton Weeks, who submitted a letter objecting to the Plan which was incorporated in the record of the administrative proceedings. The laws of Massachusetts do not provide for any further administrative remedy for appealing a decision by the Commissioner. Mr. Tierney and Ms. Marah have exhausted their administrative remedies and their claims against the Commissioner is ripe for judicial review.

68. On January 10, 2000, Mr. Tierney made demand upon JHM pursuant to M. G.L. c. 93A, § 9, on behalf of himself and all similarly situated class members, to settle the claims of all such class members. Ex. G. On February 9, 2000, Defendants responded, but declined to make an offer of settlement. Ex. H.

CLASS ACTION ALLEGATIONS

69. This class and derivative action is filed pursuant to Mass. R.Civ.P. Rule 23, Mass. Civ.R. 23.1 and Mass. St. 231A, § 2 on behalf of existing policyholders of JHM policies before implementation of the Plan, but excluding the Defendants and JHM Management. This action is brought as a direct class action with respect to Counts I, II, III, IV, V, VI, VII, IX and X and a derivative action as to Count VIII.

70. The Class includes millions of JHM members, and is, therefore, so numerous as to make it impracticable to join all members of the respective class before the Court. The exact number of class members is unknown, but may be objectively determined from the records maintained by JHM. In many instances, such persons are unaware that claims exist or, having knowledge of such

claims, have, in most instances, sustained damages in such amounts that when taken individually are too small in number to justify the expense and effort required to bring suit separately, but whose damages are of such a significant size, if taken as a group, that they do justify this class or derivative action.

71. Common questions of both law and fact affect the rights of each member of the class.

72. Among the predominating common questions of fact and law with reference to the representative and class are:

a. Did the JHM Charter authorize the formation and implementation of the Plan?

b. Did the Plan violate the JHM Charter?

c. Did the JHM Membership contracts authorize the formation and implementation of the Plan?

d. Did the Plan violate the Members' contractual rights?

e. Did the Management of JHM owe fiduciary duties to JHM Members?

f. Did the formation and/or implementation of the Plan constitute a breach of fiduciary duty?

g. Did the Plan violate the Conversion Law, G.L. c. § 175, § 19E(3)?

h. Did the Commissioner exceed her authority and violate the Conversion Law in her December 9, 1999 Decision approving the Plan?; and

i. Did implementation of the Plan constitute unfair and deceptive conduct.

73. Representative plaintiffs Thomas Tierney and Ms. Marah will assure the adequate representation of all members of the class, and have no conflict with class Members in the maintenance of this class action. Their claims are not only typical but virtually identical to the claims of the class members. They are is aware that they cannot settle this action without Court approval. Their interests in this action are antagonistic to the interests of Defendants and they will vigorously pursue the claims of the Class.

74. Representative Plaintiffs can acquire the financial resources to litigate this action. Moreover, undersigned counsel have agreed to pay all reasonable and necessary costs to litigate this action.

75. Retained counsel, Malakoff Doyle & Finberg, P.C., Grant & Roddy, and Paul Benton Weeks are experienced in litigating both class actions and derivative actions and have handled many such actions in the state and federal courts for and on behalf of other representative Plaintiffs. Counsel are handling this case on a contingent basis and will receive compensation for their professional services only as awarded by this Court.

76. A class action provides a fair and efficient method of adjudicating this controversy. The substantive claims of the Representatives Mr. Tierney, Ms. Marah and Class Plaintiffs are virtually identical and will require evidentiary proof of the same kind and application of the same law since Defendants have treated all Class Members in a similar and/or identical manner equitable and declaratory relief is appropriate with respect to the Class.

77. There are no known unusual legal or factual issues which would cause management problems not normally and routinely handled in class actions, and because damages may be calculated with mathematical precision, the cost of administering the class fund will be minimized. Mr. Tierney and Ms. Marah believe, and therefore aver, that because Class Members may be unaware that their rights have been violated, or, if aware, would be unable to secure counsel to litigate their claims on an individual basis because of the relatively small nature of their damages in relation to the value of the professional services which would have to be rendered, that a class action is the only proceeding in which they can claim a declaratory judgment and/or recover damages. Individual actions, as a result of the doctrine of *stare decisis*, would most likely substantially impair the rights of the Class Members and an inconsistent adjudication would require Defendants to treat similarly and/or identically treated Class Members differently.

COUNT I: M. G.L. c. 30A
The Insurance Commissioner Made An Error Of Law In Failing To Comply With The Provisions Of The Conversion Law

78. The foregoing Paragraphs are incorporated.

79. Prior to the conversion from a mutual life insurer to a stock company, a conversion plan must be approved by the Commissioner as complying with the provisions of the Conversion Law. Specifically, M. G.L. c. 175, § 19E(1) requires the Commissioner to find that the Plan conforms with the requirements of the Conversion Law and is "not prejudicial to the policyholders of such company or to the insuring public", after a hearing thereon.

80. The Commissioner's Decision, finding that the Plan was in compliance with the Conversion Law was an error of law and in excess of her statutory authority in that it construed the statute to permit an unconstitutional taking, which interpretation violates fundamental precepts of statutory construction, and cannot be reconciled with recognized law, the insurance policies or the JHM Charter. Property rights acquired pursuant to the JHM Charter and Members' contracts cannot constitutionally be taken from JHM Members in the manner proposed by the Plan and the Commissioner does not have authority to approve such an unconstitutional taking of property in contravention of the Conversion Law, the Charter and Members' contracts.

81. JHM Members have been damaged, *inter alia,* by the implementation of the Plan's unauthorized Historical Plus formula for determining ownership interest in JHM, and their interests have been substantially diminished by the Commissioner's December 9, 1999 decision approving the "Plan of Reorganization of John Hancock Mutual Life Insurance Company".

82. The Commissioner's interpretation and application of the Conversion Law in her Decision exceeded her statutory authority and was based upon an error of law as set forth herein.

WHEREFORE, the Plaintiffs request the following relief in their favor and in favor of the class:

a. Pursuant to G.L. c. 30A, that an order be granted for judicial review of the Commissioner's December 9, 1999 Decision;

b. Upon conclusion of that review, the issuance of a declaration that the Commissioner's approval of the Plan was in violation of constitutional provisions, exceeds statutory authority and was based upon an error of law, and should therefore be set aside pursuant to the provisions of M. G.L. c. 30A, § 14 (7);

c. A declaration that the Plan's adoption of the Historic Plus method was contrary to the Conversion Law; and

d. Such other and further relief as the Court deems appropriate.

COUNT II: Breach Of Contract
Violation Of The Charter – Unauthorized Sale

83. The foregoing Paragraphs are incorporated.

84. The Plan proposed to conclude the mutual operation of JHM by a transfer to JHFS and public sale of JHM.

85. The Charter does not authorize this method of concluding the core operating purpose of JHM under the Charter which was to operate as a mutual to provide life insurance to Members.

86. Members have not consented to this fundamental alteration or revision of the JHM Charter and were damaged by implementation of the Plan because the Charter did not authorize conversion from a mutual insurer to a stock holding company and/or the Plan did not provide for the payment of fair value to JHM Members.

WHEREFORE, Plaintiffs request the following relief in their favor and in favor the class:

a. Declaratory relief that implementation of the Plan was not authorized by the JHM 1862 Charter;

b. Actual damages, and

c. Such other and further relief as the Court deems appropriate.

COUNT III: Breach Of Contract
Violation of the Charter – Failure to Protect Participating Policy and Ownership Rights

87. The foregoing Paragraphs are incorporated.

88. The JHM Charter provided proportionate ownership rights to Members of JHM. The ownership rights included, *inter alia,* the right that JHM be operated as a mutual insurer, that their insurance contracts be "participating policies," and that if JHM is dissolved or its assets sold, that they receive the maximum going concern value of their proportionate interest in JHM.

89. The Charter provided that the Members are the owners of JHM and, that upon the cessation of operations under the JHM Charter are entitled to the residual going concern value of the insurer. Members under their contracts were entitled to an ownership share proportionate to their membership interests after all expenses liabilities and losses then incurred have been deducted.

90. The Plan has deprived Members of their contractual rights in that:

a. Members have not received the maximum value of their Membership interest;

b. Members with individual whole life and term policies contractual rights have lost their "participating policies" in exchange for inclusion in JHFS' "JHLIC Closed Block"; and

c. The Plan's use of the Historic plus method of distribution violated Members' ownership rights.

WHEREFORE, Plaintiffs request the following relief in their favor and in favor of the class:

a. Declaratory relief that implementation of the Plan was contrary to Members' contractual rights in that (1) the Plan failed to protect members' right to obtain the maximum value for their ownership interests; (2) the Plan is contrary to Members' "participating policy rights" if use of the "Closed Block" was implemented; and (3) the use of the Historic Plus method is contrary to Members' contractual rights;

b. Actual damages; and

c. Such other and further relief as the Court deems appropriate.

COUNT IV: Breach Of Contract Violation Of Charter - Unauthorized Continued Operation As A Stock Company

91. The foregoing Paragraphs are incorporated.

92. Under JHM's Charier, JHM was explicitly chartered to operate as a mutual insurance company to provide insurance on the lives of persons.

93. The JHM Charter did not authorize the conversion of JHM assets to a stock company or in any other manner other than as provided in the Charter.

94. The JHM Charter did not authorize the Plan because it proposed to divest Members of their ownership rights and to change the fundamental purpose of JHM to operate as a mutual insurer to instead operate as a stock company.

95. All Members have not consented to this fundamental change in the JFIM Charter and have been damaged by this violation of JHM's Charter.

WHEREFORE, Plaintiffs request the following relief in their favor and in favor of the class:

a. Declaratory relief that the implementation of the Plan was contrary to the fundamental character and core purpose of the 1862 JHM charter and Members' "pacipating [sic] policies."

b. Actual damages; and

c. Such other and further relief as the Court deems appropriate.

COUNT V: Breach Of Contract
Failure To Allow Participating Policyholders To Share In Cost And Expense Savings

96. The foregoing Paragraphs are incorporated.

97. Members purchased and owned "participating policies" in JHM which provided them insurance protection at cost in return for their premium payments.

98. The Plan has failed to provide Members with a "participating policy" in mutual insurer by operation of the "Closed Block." The use of the "JHLIC Closed Block" caused Members' policies to no longer be participating with respect to expenses because JHFS agreed not to charge the "Closed Block" with expenses, thus enabling JHFS to avoid the segregation of billions of dollars in assets into the "Closed Block." Moreover, if the estimated expenses are less than anticipated, policyholders will be unable to participate in the savings.

99. Members' "participating policies" did not authorize Defendants to exchange participating policies in a mutual insurer for non-participating policies in a stock company and to allow others to receive 100% of any costs and expense savings.

100. The "JHLIC Closed Block" constitutes a material contractual breach which has damaged Members.

WHEREFORE, the Plaintiffs request the following relief in their favor and in favor of the class:

a. Declaratory relief that the "Closed Block" was contrary to Members' participating policy rights

b. Actual damages; and

c. Such other and further relief as the Court deems appropriate.

COUNT VI: Breach Of Contract
Failure To Allow Participating Policyholders
To Own And Manage Their Own Assets Through
A Member Owned Mutual Insurer

101. The foregoing Paragraphs are incorporated.

102. The use of the "Closed Block" failed to provide Members with a participating policy. The "Closed Block" materially revised the manner of determining and providing investment returns on JHM's assets that secured the policies. Under their "participating policies," Members contracted that all assets now owned would be invested by Management solely to benefit Members. The "JHLIC Closed Block" undermines this contractual right by converting their property interests and by allowing the "JHLIC Closed Block" to be managed by JHFS, an entity that is conflicted by reason of divergent duties owed to Members and JHFS shareholders.

103. The "JHLIC Closed Block" constituted a material breach of Members' participating policies which has damaged Members.

WHEREFORE, Plaintiffs request the following relief in their favor and in favor of the class:

a. Declaratory relief that the implementation of the "JHLIC Closed Block" was contrary to Members' participating policy rights;

b. Actual damages; and

c. Such other and further relief as the Court deems appropriate.

COUNT VII: Breach Of Contract
Failure to Guarantee Known Policyholder Ownership Interests From The Possible Claims Of Policyholders That Are Not Located

104. The foregoing Paragraphs are incorporated.

105. The "JHLIC Closed Block" has materially altered Members' participating policies because the "JHLIC Closed Block" plan failed to adequately recognize Members mortality expectations. JHM has allegedly been unable to locate hundreds of thousands of Members, many of whom may have passed and/or their heirs. The "Closed Block" does not account for this known mortality experience risk. In addition, JHM policyholders, not JHFS. have the right to recover the ownership interests of unlocated policyholders who had an interest in JHM.

106. The "JHLIC Closed Block" constituted a material breach of Members' participating policies which has damaged Members.

WHEREFORE, Plaintiffs request the following relief in their favor and in favor of the class:

a. Declaratory relief that the implementation of the "Closed Block" was contrary to Members' participating policy rights;

b. Actual damages; and

c. Such other and further relief as the Court deems appropriate.

COUNT VIII:
Management's Breach of Fiduciary Duties

107. The foregoing Paragraphs are incorporated.

108. Management owed fiduciary duties to Members, in addition to JHM, in connection with the implementation of the proposed sale of JHM.

109. Management breached their fiduciary duties to JHM and/or Members when they:

a. Implemented the Plan contrary to their authorized power under the JHM Charter;

b. Divested JHM policyholders of their ownership interests in JHM;

c. Divested JHM policyholders of their right to control the management of their mutual insurer, JHM;

d. Failed to devise the Plan so as to assure that the value of JHM Membership rights would be maximized;

e. Devised the Plan so as to benefit Management and outside investors to the detriment of Members;

f. Unilaterally modified Members' participating policy contract rights by replacing them with the so-called "JHLIC Closed Block;"

g. Failed to obtain non-conflicted financial advisors to provide accurate information with respect to the proposed Plan;

h. Implemented the Plan, although they were conflicted by their interests to others, and thereby damaged the JHM policyholder interests;

i. Implemented the Plan and permitted Management to presume that Members failing to elect cash, policy credits or stock, would prefer cash, not stock;

j. Failed to deal fairly with the Members by failing to adequately inform themselves and/or Members about the appraised full, unrestricted fair market value or going concern value of JHM;

k. Failed to deal fairly with the Members by failing to adequately inform themselves and/or Members about the proportionate fair market or going concern value of JHM as compared to the IPO stock price;

l. Failed to procure or provide a fair price to Members in exchange for extinguishing their ownership of JHM; and

m. Implemented Plan provisions known to be contrary to the Conversion Law.

110. Plaintiffs have not made a demand on the JHM Board of Directors to institute an action against the Management Defendants for their breaches of fiduciary duties, breaches of trust and other wrongful acts as particularized in this count. Such demand would constitute a futile and useless act, and is, therefore, excused, for the following reasons:

a. The Individual JHM Board Defendants knowingly and willfully participated in the promulgation of the Plan which allowed them to control a significant percent of the stock company formed by the reorganization for inadequate consideration;

b. The Individual JHM Board Defendants failed to exercise valid business judgments because the actions

alleged amounted to self-dealing, breaches of their fiduciary duties of good faith, due care, and loyalty to JHM and their owner, and an abdication of their responsibilities as directors, which breaches and abdication gave rise to Defendants' liability for the illegal wrongdoing alleged herein, the ratification of which would be improper and unlawful; and

c. The Board of Directors of JHM would be unable to reach an independent decision as to whether to commence legal action against themselves since every member of the Board of Directors of JHM is an individual Defendant and will personally profit as a result of the improper and unlawful acts alleged herein.

111. Representatives Tierney and Marah did not make a demand on the Board of Directors to obtain the identity of policyholders of JHM or to initiate this action because it would be a futile act because:

a. JHM has approximately three million eligible policyholders; and

b. Even assuming all policyholders could be individually identified, making demands upon all of them would force Plaintiffs to incur enormous expenses, clearly unreasonable in lieu of the apparent futility of the act.

112. Mr. Tierney has communicated with Management in a series of letters that contest the propriety of the Plan. Mr. Tierney also appeared at the public hearing held by the Massachusetts Commissioner of Insurance and objected to approval of the Plan by the Commissioner. Management has squarely rejected Mr. Tierney's demands.

113. JHM Members have suffered substantial damages by reason of Management's breaches of duty.

WHEREFORE, Plaintiffs request the following relief in their favor and in favor of the class:

a. Declaratory relief that Management breached its fiduciary duties owed to Members in the manner described above;

b. Actual damages; and

c. Such other and further relief as the Court deems appropriate.

COUNT IX:
Hancock's Violations Of The Conversion Law

114. The Plan violated the Conversion Law and prejudiced the policyholders by providing for the allocation of consideration using the Historical Plus method rather than an historical only method.

115. The Conversion Law does not authorize the use of the Historical Plus Method for allocation of consideration which method is not based solely on historic indicia of contribution to surplus. Mass. Stat. § 175, § 19E(3). The Plan's use of such a formula based on non-historic criteria also violated the JHM Charter and impaired the policyholders' interests in the Charter, in that the Charter requires that upon conclusion of JHM's operating purpose the proportionate share of historic contribution to surplus must be returned to eligible Members. As such, the Plan prejudices the interests of the policyholders in violation of M. G.L. c. 175, § 19E.

116. JHM Members have been damaged by implementation of the Plan's unauthorized Historical Plus formula for allocating consideration, and their interests

have been substantially prejudiced by Commissioner's December 9, 1999 Decision approving the "Plan of Reorganization of John Hancock Mutual Life Insurance Company".

117. There is a dispute between the parties that is ripe for adjudication, there are no further administrative remedies available, and a determination by the court will completely resolve the dispute.

WHEREFORE, the Plaintiffs request the following relief in their favor and in favor of the class:

a. A declaration that the Plan's adoption of the Historic Plus method and that Plan's proposed "Closed Block" method was contrary to the Conversion Law;

b. Actual damages; and

c. Such other and further relief as the Court deems appropriate.

COUNT X:
Unfair and Deceptive Acts and Practices

118. The foregoing paragraphs are incorporated.

119. The Hancock defendants' conduct as described in this complaint violates the Massachusetts Consumer Protection Act. G.L. c. 93A, § 2, in a manner including but not limited to:

a. Failing to adhere to the dictates of the Carter [sic] in the conversion to a stock company;

b. Misrepresenting and/or failing to disclose to Members the true cost, benefits and advantages of conversion;

c. Misrepresenting and/or failing to inform Members of the true value of the company and of the value of their respective entitlements to share in the company's true value;

d. Providing information to induce Members to vote in favor of the conversion in a manner which the defendants knew or should have known failed to provide all material information necessary to Members' informed voting decision;

e. Creating a "closed block" which the defendants knew or should have known failed to provide the necessary protections which Members who held participating policies were contractually guaranteed;

f. Using a compensation distribution formula which favored newer policies to the detriment of older policies and which violated the provisions of the conversion law;

g. Failing to obtain maximum value for Members in the conversion process by the improper use of antitakeover provisions;

h. Formulating a conversion plan which placed Hancock Management in a position of conflict of interest with Members;

i. Failing to act in a fiduciary capacity to Members in devising and implementing the conversion plan; and

j. Engaging in other unfair and deceptive conduct designed to deprive the Members of the full value they were entitled to in the conversion process.

120. The conduct of Defendants was willful or knowing within the meaning of the Massachusetts Consumer Protection Act, G.L. c. 93 A, § 2.

121. The Members suffered significant economic damages by virtue of the Defendants' violations of c.93A.

122. The Defendants' actions were willful and knowing, as Defendants had knowledge or reasons to know that the acts or practices complained of violated G.L. c. 93A, § 2.

123. Defendants' refusal to grant relief upon demand was willful and knowing, in violation of Chapter 93A.

WHEREFORE, Plaintiffs request that this Court enter judgment in their favor and in favor of the class and against Defendants as follows:

a. Assessing actual and statutory damages;

b. Assessing double or triple damages against Defendants for their willful violations set forth above;

c. Awarding Plaintiffs their reasonable attorney's fees and costs; and

d. Granting such other relief as the Court deems appropriate and just. Plaintiffs demand trial by jury.

Respectfully submitted,

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VERIFICATION

COMMONWEALTH OF MASSACHUSETTS

Suffolk, ss. March 31, 2000

I, Doris G. Marah, plaintiff in the Amended Class Action Complaint captioned above, declare under the pains and penalties of perjury that I am familiar with the facts of this case, that I have read the Verified Amended Class Action Complaint, and that the facts recited herein are true and correct to the best of my knowledge, information and belief.

/s/ DORIS G. MARAH
Doris G. Marah

VERIFICATION

COMMONWEALTH OF MASSACHUSETTS

Suffolk, ss. March 24, 2000

I, Thomas Tinerney, plaintiff in the Amended Class Action Complaint captioned above, declare under the pains and penalties of perjury that I am familiar with the facts of this case, that I have read the Verified Amended Class Action Complaint, and that the facts recited herein are true and correct to the best of my knowledge, information and belief.

_____

Thomas Tierney

APPENDIX I

COMMONWEALTH OF MASSACHUSETTS

THE APPEALS COURT

Suffolk County

No. 2001-P-0435

THOMAS TIERNEY and DORIS G. MARAH, individually and on behalf of other similarly situated Policyholders of John Hancock Mutual Life Insurance Company,

Plaintiffs-Appellants.

v.

JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY, JOHN HANCOCK FINANCIAL SERVICES, INC., JOHN HANCOCK LIFE INSURANCE COMPANY and the following Directors of John Hancock Mutual Life Insurance Company, STEPHEN L. BROWN, FOSTER L. ABORN, DAVID F. D'ALESSANDRO, SAMUEL W. BODMAN, III; JOAN T. BOK; I. MACALLISTER BOOTH; WAYNE A. BUDD; JOHN M. CONNORS, JR.; ROBERT E. FAST; EDWARD H. LINDE; DR. KATHLEEN FOLEY FELDSTEIN; NELSON S. GIFFORD; MICHAEL C. HAWLEY; E. JAMES MORTON; RICHARD F. SYRON; ROBERT J. TARR, JR.; and former Directors, LAWRENCE K. FISH; WILLIAM L. BOYAN; JOHN F. MAGEE; AND CHESTER V. VAPPI; and HONORABLE LINDA RUTHARDT, COMMISSIONER OF INSURANCE, COMMONWEALTH OF MASSACHUSETTS

Defendants-Appellees

On Appeal from the Judgment of the Superior Court Department of the Trial Court in Civil Action No. 00-0087 BLS at SU-CV-000078

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4. Massachusetts R.Civ.P. 12.

* * *

Beginning of excerpt

4. The Commissioner's Interpretation Would Render § 19E Contrary To the Contracts and Takings Clauses

If reasonable principles of construction permit, a statute must be read to avoid constitutional difficulties. *School Committee v. Greenville Education Assoc.,* 385 Mass. 70, 80 (1982). Construing § 19(E)3 to require "fair consideration" avoids an unlawful impairment or taking of Members' property in violation of constitutional protections.

a. Members Had Property Interests in JHM That Were Subject To A Government Authorized "Taking"

The Takings and Contract Clauses apply where it is established that a property right is at stake and the conduct at issue constitutes a "taking." *Eastern Enterprises v. Apfel,* 524 U.S. 498 (1998); *Parrella v. Retirement Board of Rhode Island,* 173 F.3d 46, 57 (1st Cir. 1999). Members held property rights because their contracts gave them the exclusive right of control and use of the JHM property. A contract constitutes property which may be "taken" by the state. *Ruckelshaus v. Monsanto,* 467 U.S. 986, 1003 (1984); *United States Trust Co. of N.Y. v. New Jersey,* 431 U.S. 1, 19 fn. 16 (1977). Property rights in a physical thing have been described as the rights "to possess, use and dispose of it." *Loretto v. Teleprompter Manhattan CATV Corp.,* 458 U.S. 419, 435 (1982), quoting *United States v. General Motors Corp.,* 323 U.S. 373, 378 (1945) and *Kaiser Aetna v. United States,* 444 U.S. 164, 179-180 (1979). Members' contractual interests in JHM clearly constitute "property."

A "taking" within the meaning of the Takings Clause includes both government action resulting in a physical deprivation of the owner's property and government regulatory action which goes "too far" such that it undermines "distinct investment-backed expectations" derived from property ownership. *Loretto,* 458 U.S. at 432. "A permanent physical occupation authorized by state law is a taking without regard to whether the State, or instead a party authorized by the State, is the occupant." *Id.* at 432, fn. 9. *See also Hawaii Housing Authority v. Midkiff,* 467 U.S. 229, 241 (1984). Under the Conversion Law, the legislature exercised its taking power by recognizing a public use and also delegated to the converting insurer its duty to pay just compensation to Members in exchange for their bundle of rights. G.L. c. 175, § 19(E)3.[24]

The "taking" power is exercised where, as here, the Legislature authorizes a method for the alteration of a corporate charter to allow a mutual to stock conversion. *See, e.g., Appeal of Corporators of Portsmouth Savings Bank,* 129 N.H. 183, 193-94, 525 A.2d 671, 679 (1987); *Huber* 127 Wis. 412, 105 N.W. at 1037-1039. A state's charter creates a public contract protected by the Impairment Clause. *Trustees of Dartmouth College v. Woodward,* 17 U.S. 518 (1819). A state may enact a law, as the Commonwealth has, reserving the power to alter, amend or repeal corporate charters. *Looker v. Maynard,* 179 U.S. 46, 51 (1900). This reserved power is limited by the Takings Clause and Contracts Clause where its exercise would

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[24] *See also* N.Y. Ins. Law § 73 (Historical and Statutory Notes) (recognizing financial viability of insurance companies in New York as public purpose).

repudiate contractual rights which give rise to a right to "just compensation" as to prevent an "impairment" or "taking." *In Re: Opinion of Justices*, 300 Mass. at 611; *Opinion of the Justices*, 334 Mass. 721, 737 (1956); *Durfee v. Old Colony and Fall River Railroad*, 87 Mass. 230, 248 (1862) and *Holyoke Company v. Lyman*, 82 U.S. 500 (1872).

The Conversion Law authorizes a government "taking" because it provides a method creating the conditions for a third party (public investors) to take over ownership and control of the corporate enterprise from the mutual members.[25]

b. The Plan Deprived Members Of Just Compensation For The Taking Of Their Property

An unconstitutional "impairment" or "taking" can be avoided if "appropriate consideration" is read to mean "just compensation." Mass. c. Pt. 1, Art. X; U.S. Const. Amend. V. *See Bromfield v. Treasurer & Receiver General*, 390 Mass. 665, 668 (1983). The just compensation standard requires that upon a conversion of a mutual life insurance company, each policyholder should be placed in as good as position as if the conversion had not taken place. *United States v. General Motors Corporation*, 323 U.S. 373, 379 (1945); *United States v. Virginia Power and*

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[25] *See also Union Mutual*, Legal Standards Ruling at pp. 14-15 (A-756-757) citing *Ohio State Life Ins. v. Clark*, 274 F.2d 771, 775 (6th Cir. 1960); *Huber*, 127 Wis. 412, 105 N.W. at 1037-1039 and *Carlton v. Southern Mutual Ins.*, 72 Ga. 371, 402 (1884).

Electric, 365 U.S. 624 (1961). "Just compensation" means the same as "fair consideration" or an exchange of equal value. "Fair value" is compensation for what has been taken. *Weinberger v. UOP, Inc.,* 457 A.2d 701, 714 (Del. 1983) *Aff'd.* 497 A.2d 792 (1985).

As explained above, Members did not receive "just compensation" because they did not receive "equal" value (1) for giving up their interest to ownership and control; (2) by the use of the "historic-plus" allocation; and (3) by the use of the "Closed Block" which did not maintain or was not based upon Members' pre-conversion contractual rights and expectations.

B. The Superior Court Erred in Dismissing The Common Law and Statutory Claims in Counts II-X

The Hancock Defendants had an independent obligation to comply with the contractual, fiduciary or statutory protections applicable to the relation between a mutual company and its policyholders, in addition to those standards applicable under the Conversion Law.[26] The Conversion Law does not abrogate those rights. *O'Sullivan* 431 Mass. at 206. (Unless clearly expressed, statutes do not impair common law rights). The Superior Court misapplied Mass. R.Civ.P. 12 in a manner that erroneously relieved the Hancock Defendants of these obligations and

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[26] *See Doyle v. Union Insurance Company,* 202 Neb. 599, 607; 277 N.W.2d 36, 41 (1979); *Drain v. Covenant Life Insurance Company,* 712 A.2d 273 (PA 1998) and *Rowen v. LeMars Mutual Insurance Co.,* 230 N.W. 2d 905 (Iowa 1975).

violated Members' statutory and constitutional rights to recover property damages in court with a right to a jury trial.

1. The Dismissal of the Common Law and c. 93A Claims Violated Mass. R.Civ.P. 12

A Rule 12(b)6 motion to dismiss for failure to state a claim may be converted to a motion for summary judgment where " . . . matters outside the pleadings are presented to and not excluded by the court." Where a court utilizes this procedure " . . . all parties shall be given reasonable opportunity to present all material made pertinent to such motion by Rule 56." Statutory App. Ex. 4.

Here, Rule 12(b)'s conversion provision was never triggered because the parties did not present matters "outside the pleadings" on the Hancock Defendants motion to dismiss. A-914-916. The Hancock Defendants argued, *as a matter of law,* that Counts II-X should be dismissed pursuant to Rule 12(b)6 as "indirect challenges" to the Commissioner's decision. However, they did not rely on the administrative record as Rule 56 support for their defenses nor did they request that the Court enter judgment pursuant to Rule 56. A-914-916. The Court looked to the administrative record to decide the sufficiency of the pleadings under G.L. c. 30A because the Commissioner filed the administrative record "by way of answer." G.L. c. 30A § 14(4). This does not convert the motion to dismiss to a Rule 56 motion since the court can utilize the agency record to decide legal, not factual issues requiring *de novo* review. See *Marshall County Health Care v. Shalala,* 988 F.2d 1221 (Dist. Col. Cir. 1993); *Mack v. South Bay Beer Dist.,* 798 F.2d 1279, 1282 (7th Cir. 1986). Here, the

Superior Court violated Rule 12 by looking to the administrative record to test the factual sufficiency of the damages claims under Rule 56 standards.

The Superior Court's failure to notify the plaintiffs of its intent to consider the motions under Rule 56 was also legal error. *White v. Peabody Construction Co.,* 386 Mass. 121, 127 (Mass. 1982) (Citing 2A Moores Federal Practice par. 12.09(3), at 2302 n.25 (2d Ed. 1982); 5A *Wright and Miller, Federal Practice and Procedure,* § 1366, at 683).[27] *Gomes v. Metropolitan Property & Casualty Insurance Company,* 45 Mass. App. Ct. 27, 32 (1998) *review denied* 700 N.E.2d 544 (Mass. 1998). Under *Gomes,* Members are entitled to an opportunity to submit evidence and argument in opposition.[28]

2. The Superior Court's Misapplication of Rule 12 Deprived Members Of Statutory, Common Law and Constitutional Rights

The Superior Court's use of the Commissioner's decision to factually determine the damages claim was

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[27] *See also Maldonado v. Dominguez, et al.,* 137 F.2d 1 (1st Cir. 1998); *Collier v. City of Chicopee,* 158 F.3d 601 (1st Cir. 1998) *cert. denied* 526 U.S. 1023 (1999).

[28] The Superior Court also erred in stating that Mass. R.Civ.P. 23.1 applied to Members' Breach of Fiduciary Duty claims. A-1165. This action is a direct action seeking recovery for "private wrongs," not a derivative claim for corporate wrongs, since JHM does not even exist anymore. *Crowley v. Communications for Hospitals,* 30 Mass. App. Ct. 751, 764 (1991). In any event, demand would have been futile given the claims here that Management was "conflicted" by its pecuniary interest in the conversion. *Harhen,* 431 Mass. at 845. Even more, Tierney and others made demands that were rejected. E-63-179.

erroneous because administrative agencies generally lack statutory and constitutional authority to adjudicate or decide claims for damages. *See Liability Investigative Fund Effort, Inc. v. Medical Malpractice Joint Underwriting Association,* 409 Mass. 734, 751 (1991); *cert. denied* 513 U.S. 1058 (1994); *Hartford Accident & Indemnity Co. v. Commissioner of Insurance,* 407 Mass. 23, 29-30 (1991) (Commissioner had no authority to consider plaintiff's constitutional claims); *J. & J. Enterprises, Inc. v. Martignetti,* 369 Mass. 535, 539-540 (1976) (reversing dismissal of a damages action for unfair trade practices, where the agency had "no power to prosecute civil actions to recover damages on behalf of persons aggrieved. . . .") The Commissioner acknowledged as much in her October 27, 2000 decision on Mutual of America's Motion to Intervene in the Hancock proceeding, (recognizing that breach of contract claims were beyond the scope of a § 19E proceeding) Admin. Record doc. pp. 396-397. The Commissioner's decision on the merits also recognized that § 19E did not authorize, let alone require her, to resolve public information dissemination issues:

> § 19E does not specify the scope of the notice or information that an insurer seeking to demutualize must provide to its policyholders. Nor does it require the Plan, which by its very nature, is a complicated document, to be fully comprehensible by each and every policyholder.

E-26.

The Members have waited until the conclusion of administrative proceedings and have therefore satisfied the doctrine of prior resort as set forth in *Martignetti,* 369 Mass at 648. They are now entitled to press the damage claims that the Commissioner could not decide.

Moreover, Members hold a "sacred" right to have their controversy with the Hancock Defendants concerning their contracts, statutory rights and property to be decided at trial by a jury and to obtain a remedy for the loss of their property. Mass. Const. Pt. 1, Art 10, 11 and 15; *Lavelle v. Massachusetts Comm. Against Discrimination,* 426 Mass. 332 (1997). Here, as in *Lavelle,* the Superior Court substituted administrative decision-making for adjudication of common law claims before a jury. It may not lawfully do so pursuant to rights granted to Members by Mass. Const. Pt. 1, Art.15 and Mass. Const. Pt. 1, Art. 30.

V. CONCLUSION

For the foregoing reasons, this Court should (1) reverse the judgment of the Superior Court with respect to Members' Count I claim based upon G.L. c. 30A, § 14(7) with instructions to vacate the December 9, 1999 Decision of the Commissioner for its failure to apply proper legal standards and for exceeding statutory and constitutional authority; (2) reverse the judgment of the Superior Court with respect to Counts II through X of the Complaint; and (3) remand this action to the Superior Court for further proceedings consistent with this Court's decision.

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Dated: May 23, 2001

APPENDIX J

COMMONWEALTH OF MASSACHUSETTS
SUPREME JUDICIAL COURT

SUFFOLK COUNTY

APPEALS COURT NO 2001-P-0435

THOMAS TIERNEY and DORIS G. MARAH, individually and on behalf of other similarly situated Policyholders of John Hancock Mutual Life Insurance Company,

Plaintiffs-Appellees,

v.

JOHN HANCOCK MUTUAL LIFE INSURANCE COMPANY; JOHN HANCOCK FINANCIAL SERVICES, INC., JOHN HANCOCK LIFE INSURANCE COMPANY and the following Directors of John Hancock Mutual Life Insurance Company, STEPHEN L. BROWN, FOSTER L. ABORN, DAVID F. D'ALESSANDRO, SAMUEL W. BODMAN, III, JOAN T. BOK, I. MACALLISTER BOOTH, WAYNE A. BUDD, JOHN M. CONNORS, JR., ROBERT E. FAST, EDWARD H. LINDE, DR. KATHLEEN FOLEY FELDSTEIN, NELSON S. GIFFORD, MICHAEL C. HAWLEY, E. JAMES MORTON, RICHARD F. SYRON, ROBERT J. TARR, JR.; and former Directors, LAWRENCE K. FISH, WILLIAM L. BOYAN, JOHN F. MAGEE, AND CHESTER V. VAPPI, and HONORABLE LINDA RUTHARDT, COMMISSIONER OF INSURANCE FOR THE COMMONWEALTH OF MASSACHUSETTS

Defendants-Appellants.

On Appeal from a Judgment of the Superior Court

APPLICATION OF APPELLANTS FOR FURTHER APPELLATE REVIEW

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Claims Against the Company: Despite the Company's broad leeway, under the rulings below, in deciding price and other matters affecting the policyholders, the Lower Courts construed the Conversion Law to supercede contract, common law and statutory claims that were not (and could not have been) before the Commissioner.

A basic precept of statutory construction is that if the Legislature had intended to alter the legal rights and obligations of a contract or to abolish common law rights, it would have done so expressly. *Nantucket Conservation Foundation v. Russell*, 380 Mass. 212, 214 (1980); *Riley v. Davison Construction*, 381 Mass. 432, 438-39 (1980). The Conversion Law contains no express provisions eliminating any substantive rights.[14] The Commissioner herself read the statute correctly, acknowledging that she never had jurisdiction over the contract or other claims and she expressly disclaimed authority over the adequacy of the notice. (E-26).[15] The Commissioner's refusal to adjudicate

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[14] Nor could the statute be read to totally eliminate Members' right to full contract damages. An unconstitutional contract impairment involves the elimination of a remedy by the state for the breach. *Hays v. Port of Seattle*, 251 U.S. 233, 237 (1920) (Had the Legislature . . . passed an act . . . to diminish his compensation, . . . there would no doubt have been an attempted impairment of the obligation.) *Lynch v. United States*, 292 U.S. 571, 580 (1934) ("whenever the right to enforce them by legal process is taken away or materially lessened," the Contracts Clause is violated).

[15] On the notice issue, the Appeals Court strained, once again, to find a sort of implicit resolution of the issues. It said that the Commissioner was "not without experience" in evaluating notices, that the adequacy of the notices was somehow "intertwined" with the fairness of the plan itself and that the Court would therefore "defer[ ]" to the

(Continued on following page)

these claims was correct. See *Liability Investigative Fund Effort v. Medical Malpractice Joint Underwriting Association*, 409 Mass. 734, 751 (1991), cert. denied, 513 U.S. 1058 (1994); *J. & J. Enterprises, Inc. v. Martignetti*, 369 Mass. 535, 539-540 (1976).

Even worse, the Appeals Court has erroneously construed the Conversion Law to divest Members of their right to adjudicatory due process, including a trial before a jury on their common law, statutory and contractual claims. *Lavelle v. Massachusetts Comm. Against Discrimination*, 426 Mass. 332 (1997); Mass Const. Pt. 1, Arts. 15 and 30. The Appeals Court concedes that the Members have property interests, but then construes the Conversion Law to eliminate Members' right to a judicial determination for injury to these rights. This refusal to adjudicate Members' property claims, has deprived them of the process that is due. *Madera v. Secretary of the Exec. Off. of Communities & Development*, 418 Mass. 452 (1994).

The contract, common law and other rights of Members supplement § 19E. JHM made numerous choices that are not dictated by § 19E including, to select a method of compensating Members, and to make certain public disclosures, but not to make other disclosures. In making those choices, it was bound to follow § 19E *and* its contracts, common law duties and other statutes.

Commissioner – begging the question whether the Commissioner had decided anything to which the Court could defer.

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APPENDIX K

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK, ss

SUPERIOR COURT
DEPARTMENT OF THE
TRIAL COURT

CIVIL ACTION NO.: 00-00087

THOMAS TIERNEY and DORIS G. MARAH, individually and on behalf of other similarly situated policyholders of John Hancock Mutual Life Insurance Company,

Plaintiffs,

v.

John Hancock Mutual Life Insurance Company, John Hancock Financial Services, Inc., John Hancock Life Insurance Company and the following Directors of John Hancock Mutual Life Insurance Company, Stephen L. Brown, Chairman of the Board, Chief Executive Officer and Director; Foster L. Aborn, Vice Chairman of the Board, Chief Investment Officer and Director; David F. D'Alessandro, President, Chief Operations Officer and Director; Samuel W. Bodman, III; Joan T. Bok; I. MacAllister Booth; Wayne A. Budd; John M. Connors, Jr.; Robert E. Fast; Edward H. Linde;

Dr. Kathleen Foley Feldstein; Nelson S. Gifford; Michael C. Hawley; E. James Morton; Richard F. Syron; Robert J. Tarr, Jr.; and former Directors, Lawrence K. Fish; William L. Boyan; John F. Magee; and Chester V. Vappi; and Honorable Linda Ruthardt, Commissioner of Insurance, Commonwealth of Massachusetts, Defendants.	**PLAINTIFFS' MEMORANDUM IN SUPPORT OF MOTION FOR JUDGMENT ON THE PLEADINGS**

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IV. LEGAL ARGUMENT

A. The Commissioner Was Required, But Failed, To Construe The Conversion Statute To Assure Protection Of Members' Contractual 1862 JHM Charter Rights

The Massachusetts and Federal Constitutions both recognize that a person's property cannot be appropriated without their express consent unless the taking is authorized by the government for a public use and then only if just compensation is paid. G.L. Const. Pt. 1. Art 10: U.S. Const., Amend. V. Mutual insurance company policyholders are property owners that own the mutual company. Their property cannot be appropriated without their express consent or without governmental authorization for a proper public use and only then if just compensation is paid.

The General Court enacted Section 19E in 1991, authorizing the appropriation of mutual membership interests to create private stock companies pursuant to its power to act for the "good and welfare of this Commonwealth," so long as "appropriate consideration" is paid. G.L. Const. Pt. 2, C.1. § 1, Art. 4 and § 19E. The General Court's power was expressly limited by G.L. Const. Pt. 1. Art. 10 which requires that such appropriation be coupled with just compensation. The General Court satisfied this basic constitutional protection in Section 19E by requiring that "appropriate consideration" be paid for the membership appropriation. The Commissioner's interpretation of Section 19E here, however, failed to require the requisite

just compensation for the appropriation of Members' property. The Commissioner was *constitutionally* required to interpret Section 19E to protect Members' contractual property interests. As explained in a similar case by the New Hampshire Supreme Court:

> . . . we start from the constitutional principle that the board may, in its wisdom, encourage conversions of mutual banks by adopting regulations such as Tru 506.02, *but the regulatory scheme cannot supplant the depositors' charter rights.* U.S. Const, art 1. § 10 ("No state shall . . . pass any . . . law impairing the obligation of contracts . . .); N.H. Const. pt. 1. art. 23 (prohibiting retrospective laws). The language of part 1. article 23 is crystal clear: "Retrospective laws are highly injurious, oppressive and unjust."

Appeal Corporations of Portsmouth Savings Bank, 129 N.H. 183, 194, 525 A.2d 671, 679 (1987) P. JOP App. Ex. 4.

Instead, the Commissioner applied Section 19E here to allow the Members to be deprived of their constitutionally protected property. The JHM Members' substantial property interests in JHM could only be appropriated by governmental authorization upon payment of just compensation. That just compensation was not paid here.

1. Members Owned And Controlled JHM Pursuant To The 1862 Charter

JHM was chartered by the Commonwealth of Massachusetts in 1862. Chapter 125 of the Acts and Resolves of 1862. Amended Complaint. Ex. I. ("JHM Charter") The JHM Charter provided that JHM was authorized by the Commonwealth to operate as a "mutual life insurance

company" and created contractual ownership and control rights for JHM Policyholders upon the purchase of a participating policy.

The JHM Charter created a tripartite contractual relationship. The Charter constitutes not only a contract between the Commonwealth and JHM that authorizes JHM to provide life insurance on a mutual basis, but a contract between JHM and its owners – the policyholders, as well as a contract among the body of Members. *See In Re: Opinion of the Justices,* 300 Mass. 607, 612-13 (1938); *In Re: Opinion of the Justices,* 237 Mass. 619, 622 (1921); *Commissioners On Inland Fisheries*, 104 Mass. 446 (1870); and *Dartmouth College v. Woodard,* 17 U.S. (4 Wheat.) 518 (1819).[4]

The charter and by-laws of a mutual insurance company are embodied as contractual terms to the same effect as if fully set forth in the policy. *Amesbury v. Bowditch Mutual Fire Insurance,* 72 Mass. 596 (1865). JHM Members derived contractual rights through their JHM contracts of life insurance, the Charter and the By-laws.

The JHM "mutual life insurance company" Charter provided substantial contractual rights to its Members. A

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[4] *See also* Fletcher, Encyclopedia of Private Corporations § 3657 "Charter as Contract." Also *See Hartford Accident & Indemn. Co. v. W.S. Dickey Clay Mfg. Co.,* 24 A.2d 315, 322 (Del. 1942) P. JOP App. Ex. 5 ("Regarding the charter as a contract, it has such status as between the State and the corporation, as between the corporation and its shareholders, and, in some respects, as between the shareholders among themselves."). Massachusetts courts often rely on Delaware court decisions applying corporate law principles. *See Harhen v. Brown,* 46 Mass. App. Ct. 793, 803 (1999).

"mutual life insurance company" has a common, well-known meaning in Massachusetts which is a cooperative enterprise in which both the ownership and control of the corporate assets resides exclusively with the policyholder, and solely for the purpose of obtaining insurance at cost. *Harhen v. Brown,* 46 Mass. App. Ct. 793, 888 (1999), rev'd. on other grounds, 2000 Mass. LEXIS 368 (June 27, 2000).

At least four criteria define a mutual insurance company: (1) policyholders have membership rights to the exclusion of others and the right to choose management; (2) the mutual exists *only* for the purpose of obtaining insurance at cost; (3) members are entitled to the return of premiums in excess of those amounts needed to cover losses and expenses; and (4) common equitable ownership of the assets by members. Rev. Ruling 74-196. 26 C.F.R. 1.6501(c)(15)-1 ["Mutual insurance company; definition"]. P. JOP App. Ex. 6.

A person becomes an owner of a mutual company by purchasing a "participating policy." *Mutual Insurance Co. of Germantown v. United States,* 142 F.2d 344, 348 (3d Cir. 1944), citing 21 Am. & Eng. Ency of Law (2d Ed. 264-266) ("Membership dates in each case from the time when the insurance is effected" and "membership ceases upon termination of the policy."). In a mutual company, each member is the insurer of the others in the sense that his/her cash premium supplies the capital with which to reimburse other members for losses when they occur. *Id.* at 34.

The policyholders own and control the mutual's corporate assets since they provide the equity capital. The policyholders infuse equity through premium payments for the sole purpose of obtaining insurance at cost, rather

than to earn profit. *See* Hansman, *The Organization of Insurance Companies,* Journal of Law, Economics and Organization, Vol. 1, No. 1 (Fall 1985). P. JOP App. Ex. 7. In return for the infusion of equity capital, policyholders in a mutual insurer are recognized to be the equitable owners of the company:

> For corporate purposes only, the corporate entity owns the property, otherwise it belongs to the members. *No principle of law is more firmly founded in reason and none more important to be kept in bold relief by courts so as to challenge the attention of those who have to do with corporate affairs,* especially corporations dealing with the subject of insurance. The officers of such a concern have no greater authority over its assets, as regards appropriating the same to their private use, than those in other corporations. (emphasis added).

Huber v. Martin, 105 N.W. 1031, 127 Wis. 412 (1906). P. JOP App. Ex. 8.

Policyholders in a mutual life company have exclusive "control" of the corporate assets. *See e.g., Keystone Automobile Association v. Commissioner of Insurance,* 122 F.2d 886, 890 (3d Cir. 1941) (fundamental characteristic of mutual insurance is exclusive ownership and control of enterprise by its members). In a mutual company, the members provide capital in order to obtain the exclusive use of the services to be provided.[5] A key distinction

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[5] *See* Packel, *Organization and Operation of Cooperatives,* pp. 4-5 (4th Ed. 1970 American Law Institute) P. JOP App. Ex. 9 (Members are limited to those who will avail themselves of the services furnished by the association.).

between ownership and control, in a mutual, as opposed to a stock company, is the "personal" character of the ownership by the insureds.[6] Control in a mutual is characterized by exclusive democratic rule by members to the exclusion of any group other than the members. Packel at p. 4. P. JOP App. Ex. 9.

Members of JHM obtained their contractual rights through the JHM Charter under which the Commonwealth granted JHM the duties and obligations to operate as a mutual. The General Court, at the time the Charter was granted in 1862, recognized that mutual members had proportionate rights in the mutual's profits based upon the amounts they *paid*:

> Every member of a mutual company shall at the expiration of his policy have *a share in the profits* of the company during the time his policy was in force *in proportion to the sums by him paid on account of said policy according to the contract or policy,* after all expenses, liabilities and losses then incurred have been deducted.

Mass. Pub. Sa. (1858) Chapter 58, § 51 (1855) P. JOP App. Ex. 10.

The Members' full ownership and control of JHM was based upon their proportionate infusions of capital from their premium payments.

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[6] *See Keystone Automobile,* 122 F.2d at 886, ("it is particularly important to remember that the association is an organization of individuals rather than a mere abstract and impersonal entity.").

2. Members Ownership Interests In JHM Could Not Be Appropriated Or Modified Without Each Members Express Consent Except Pursuant To Statutory Authority Upon Payment Of Just Compensation

The JHM Management could not unilaterally sell JHM (a mutual company) or change to a stock operation without the express written consent of all its Members. A mutual to stock conversion involves material modifications of its members' vested contractual rights that necessitate express consent by each member. *See Dessauer v. Supreme Tent. Knights of The Maccabees,* 210 S.W.2d 896, 898 (Mo. 1919) citing *Grand Lodge v. Stator,* 44 Mo. App. 445, 452 (1891) P. JOP App. Ex. 11 ("An insurance contract, such as we have here, is as sacred as any other contract, and it cannot be modified or changed . . . except by the *express consent* of the member").

A member under a mutual insurance charter has dual contractual duties and rights as both the insurer and insured. *Reynold v. Supreme Council Royal Arcanum,* 192 Mass. 150, 155 (1906). As insurer, the member may expect his duties to be modified by a corporate vote. *Id.* at 15. However, the members' rights as an insured under a contract of insurance cannot be revised *without express consent. Id.* at 158. *See Miller v. Tuttle,* 73 P. 88, 89 (Kan. 1903) citing *Covenant Mutual Life Assn's v. Tuttle,* 87 Ill. App. 309, 310 – P. JOP App. Ex. 12:

> Notwithstanding that by the contract of insurance the plaintiff became a member of the association, the insurance is a contract which cannot be altered without the consent of both parties. His character as a party to the contract of insurance is not merged into his character as a member of the association. The fact that the plaintiff is a member of

> such beneficiary association does not of itself confer upon the association power to change or modify his insurance contract, without his consent, by subsequently enacted by-laws.

See also McClement v. Supreme Court I.O.F., 88 Misc. 475, 152 N.Y.S. 136 (1914), P. JOP App. Ex. 13.

A statutory charter, like the JHM Charter, cannot be retroactively rescinded to authorize a stock, rather than mutual corporate operation, since such a rescission would impair vested contractual rights that have accrued under the charter. *In re: Opinion of Justices,* 300 Mass. at 611 (1938) ("The constitutional provisions prohibiting the taking of property without compensation, or without due process of law, stand firm against impairment by amendment ... ") Legislation cannot be applied to retroactively deprive contractual rights. *See Opinion of the Justices,* 334 Mass. 721 (1956) (statutory changes may not impair vested rights); *In re: Opinion of the Justices,* 300 Mass. at 612. (The General Court may change terms of charter provided there is no violation of other constitutional guarantees); *Durfee v. Old Colony And Fall River Railroad,* 87 Mass. 230, 248 (Mass. 1862) (a statutory corporate charter is a contract between the state and the corporation and its shareholders which may be altered by subsequent legislation so long as it does not impair existing contracts). *See also Holyoke Company v. Lyman,* 82 U.S. 500 (1872) ("The legislature may, under certain circumstances alter the charter, but they cannot do anything to affect or destroy any rights of property acquired under the charter; and if under such reservation they attempt to violate any contract they have made, they are met by a higher power than their own, which forbids it."); *Appeal of Corporations of Portsmouth Savings Bank,* 129 N.H. at 193, ("The Bank's duties are determined by its charter"). P. JOP App. Ex. 4.

Under Massachusetts common law and the Members contracts, JHM could not have lawfully converted to a stock company without the express written consent of all of its policyholders. However, the General Court has the power to effect fundamental corporate changes without express individual consent pursuant to G.L. Const. Pt. 2. C.1. § 1. Art. 4 and G.L. Const. Pt. 1. Art. 10. The Commonwealth may employ its legislative power to substantially modify or rescind corporate charters even if they cause impairment of existing contracts so long as just compensation is paid. *See Opinion of the Justices,* 300 Mass. at 613, ("property rights acquired upon faith of the charter cannot be taken away under the guise of repeal or amendment without full compensation.")[7]

* * *

End of excerpt

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[7] As explained in *Black v. Delaware & Raritan Canal Co.*:

> . . . the legislature may authorize shares in corporations, and corporate franchises, to be taken for public uses upon just compensation . . . Under this paramount right in the public, subject to which all private property is held, the franchises of one corporation have been, and may be taken and bestowed upon another . . .

24 N.J. Eq. 455, 463 (N.J. 1873) P. JOP App. Ex. 14. *See also* Victor Morawetz Private Corporations 1050 (1886) quoted in Taylor, *Evolution of Corporate Combination Law: Policy Issues And Constitutional Questions,* 76 N.C.L.R. 687, 1014 (1998):

> . . . a state may enable any portion of the shareholders in a corporation to dissolve their association and consolidate with another company, or to engage in an entirely new enterprise, *upon making just compensation to such shareholders as are not willing to accept the change.* (emphasis added)